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ABSTRACT

The objectives of the research project described in this report are: (1) to determine if there have been changes in local educational and health institutions relevant to the objectives of Project Head Start; (2) to determine if local Head Start centers were influential in bringing about relevant changes in community institutions; (3) to analyze how Head Start was involved in the institutional change process; and (4) to describe the different impacts on community institutions of various Head Start characteristics and approaches. Field research was undertaken in a national sample composed of 58 communities with full-year Head Start programs and seven communities with little exposure to Head Start. Intensive studies in 42 of the Head Start communities revealed that individuals and groups associated with Head Start programs had been involved in bringing about changes in health and educational institutions. A total of 1,496 changes consistent with Head Start goals and philosophies were identified. Examples of changes are: increased involvement of the poor with institutions, greater employment of local people in paraprofessional occupations, more educational emphasis on the particular needs of the poor and minorities, and modification of health services and practices to serve the poor more effectively. (Author/NH)

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KIRSCHNER ASSOCIATES, INC.

A NATIONAL SURVEY OF THE IMPACTS OF HEAD START CENTERS ON COMMUNITY INSTITUTIONS

Contract No. B89-4638

Prepared for

Project Head Start
Office of Child Development
U.S. Department of Health, Education, and Welfare

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May 1970

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SUMMARY

OBJECTIVES OF THIS PROJECT

Project Head Start has a number of goals designed to improve the opportunities and achievements of the children of the poor. These goals have been stated as follows:[1]

--Improving the child's physical health and physical abilities.

--Helping the emotional and social development of the child by encouraging self-confidence, spontaneity, curiosity, and self-discipline.

--Establishing patterns and expectations of success for the child which will create a climate of confidence for his future learning efforts.

--Increasing the child's capacity to relate positively to family members and others while at the same time strengthening the family's ability to relate positively to the child and his problems.

--Developing in the child and his family a responsible attitude toward society, and fostering constructive opportunities for society to work together with the poor in solving their problems.

--Increasing the sense of dignity and self-worth within the child and his family.

Most research concerning Head Start has focused on determining how successful the program has been in helping children with whom it works. It must be recognized that Head Start is also vitally concerned with influencing the environment in ways deemed beneficial to the children of low-income families. This is inferred from many of the Head Start goals noted above which cannot be accomplished solely as a result of the association of a child or his family with Head Start. For these goals to be achieved it is obviously necessary that the philosophies, practices, and activities of other community institutions become more sensitive and responsive to the needs of the poor and their children. The research effort described in this report deals with this aspect of Head Start, i.e., the impacts of Head Start on the community and particularly selected crucial community institutions.

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[1] Report prepared for the Office of Economic Opportunity by a Panel of Authorities on Child Development, Robert Cooke, Chairman. 1964 GP 923-454.

More specifically, the objectives of the research project described in this report are as follows:

1. To determine if there have been changes in local educational and health institutions relevant to the objectives of Project Head Start;

2. To determine if local Head Start centers were influential in bringing about relevant changes in community institutions;

3. To analyze how Head Start was involved in the institutional change process;

4. To describe the different impacts on community institutions of various Head Start characteristics and approaches.

Thus, this project attempts to obtain a greater understanding of Head Start's role in influencing changes in community institutions. More broadly, it is hoped that it will illuminate the general question of how to achieve changes in local institutions utilizing a nationwide educational innovation as the intervention strategy.

ORGANIZATION OF PROJECT

This project was undertaken during the period from July 1968 through January 1970 and was divided into a preliminary phase, a Phase I and a Phase II. During the preliminary phase the basic project design was developed and informal investigations were conducted to determine if local institutions had changed in ways consistent with Head Start goals. The informal preliminary investigation indicated that the institutional changes that had occurred recently and that appeared to have been stimulated by Head Start were in two major areas: health and education.

Phase I of the project, which followed, was designed to determine systematically if community health and educational institutions had changed in specific ways relevant to Head Start. To make this determination, field research was undertaken in a national sample composed of 58 communities with full-year Head Start programs. The final phase of the field work was conducted in 42 of the original 58 communities. In these 42 communities, a total of 47 specific changes in health and educational institutions were studied intensively. These investigations were to determine how Head Start had been involved in bringing about these changes. Systematic field investigations were also conducted in seven communities with little or no exposure to Head Start and the results were compared with similar communities that had had more extensive Head Start experiences.

By the fall of 1968, when the field research was started, summer Head Start programs had been offered for three or four years but most of the full-year programs had been in operation scarcely a year. Further, the field work was not designed to identify all possible impacts of Head Start. Consequently, to measure the impacts of Head Start by reference solely to the number of changes identified in this project would be inconsistent with the intent of the project as well as an underestimate of the influence of Head Start.

FINDINGS

Identification of Relevant Institutional Changes

The field work was designed to identify changes in local educational and health institutions that seemed most consistent with Head Start policies and programs including:

> --Increased involvement of the poor with institutions, particularly at decision-making levels and in decision-making capacities.
>
> --Increased institutional employment of local persons in paraprofessional occupations.
>
> --Greater educational emphasis on the particular needs of the poor and of minorities.
>
> --Modification of health institutions and practices to serve the poor better and more sensitively.

Head Start itself involves parents in its programs, employs neighborhood people in paraprofessional roles, is concerned with the special needs of the poor and of minorities, and emphasizes better medical services for Head Start families. Thus, the field work sought to determine if other institutions, particularly educational and health institutions, had changed to reflect these same concerns.

Institutional changes consistent with Head Start goals and philosophies were identified in all of the communities investigated. A total of 1496 changes were identified in the 58 communities studied. The number of institutional changes per community varied from 14 to 40. In over half of the communities surveyed, more than 25 changes were identified. In no cases were there only isolated instances of change. Thus, while it cannot be said at this stage of the analysis that Head Start caused these prevalent institutional changes, it can be seen that changes of a type desired by Head Start have generally occurred in substantial numbers. Reference to the comparison communities (those without Head Start centers) reveals that almost no relevant institutional changes were identified.

An effort was made to identify the number of educational and health changes and to determine their relative distribution by community. Of the total of 1496 changes identified in the 58 communities, 1055 were educational in nature and 441 were classified in the health category. There are no cases where there are solely health or educational changes in a community. As might be expected, the distribution of changes by community is consistent with the overall finding that about 80 percent of the changes identified are in the educational area. The data thus indicate not only that community changes consistent with Head Start goals have occurred on a widespread basis but that these changes are prevalent in both educational and health fields, two of the areas of predominant Head Start concern.

As previously indicated, certain types of institutional changes are considered particularly responsive to Head Start. There is some overlap between this categorization, which follows, and between the somewhat broader distinction between educational and health changes. The 1496 changes identified are distributed as indicated on the following table.

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TABLE S-1

Number of Institutional Changes in
Each of Four Categories

Category of Institutional Change	Frequency	Percent of Total
Increased involvement of the poor with institutions, particularly at decision-making levels and in decision-making capacities	305	20.3
Greater employment of local persons in paraprofessional occupations	51	3.4
Greater educational emphasis on the particular needs of the poor and of minorities	747	50.0
Modification of health services and practices to serve the poor better and more sensitively	393	26.3
Totals	1496	100.0

In most cases all four types of changes have been identified in a community. Never were fewer than three types of change reported. It is concluded, therefore, that a variety of the important Head Start goals and concepts have been widely adopted. The examples below indicate the types of changes that occurred in these categories.

Increased involvement of the poor with institutions, particularly at decision-making levels and in decision-making capacities.

--In a small southwestern village a grass-roots organization has formed a group of Spanish-speaking parents to pressure for changes in school policies and practices. An issue currently in focus is the school system's lunchroom regulation against students bringing rather than buying lunch. (Many cannot afford the lunches.)

--In the South, low-income people in one community have recently increased their use of public health services and have voiced their opinions regarding improvements needed in the health institution's practices and policies. In response, the health institution has desegregated its waiting room, assigned patients to specific doctors, and opened the facilities one evening a week.

Employment of paraprofessionals.

--A midwestern school system has employed indigenous teacher aides in poverty neighborhoods to tutor children after school.

--A large city school system utilizes paraprofessionals almost entirely in its summer recreation project in the ghettos.

Greater educational emphasis on the particular needs of the poor and minorities.

--Low-cost (and even free) meals are now available to needy youngsters in many communities. Some schools serve a nutritious breakfast, lunch, and an afternoon snack.

--A midwestern school system has placed social workers in ghetto neighborhood schools. Most of these new staff members are black.

Modification of health services and practices to serve the poor more effectively.

--In the South, a mental health facility has been desegregated and actively reaches out to black neighborhoods through churches and anti-poverty programs.

--In Appalachia, a visiting nurse program has been established for the purpose of providing routine nursing care to the sick in an area with a paucity of medical services.

The Impact of Head Start on Community Institutions

Institutional changes took place in a complex social environment generally characterized by the existence of a wide variety of programs and forces. Consequently, it is exceedingly difficult to isolate particular institutional changes and attribute them solely to the existence of Head Start. Nevertheless, the evidence collected in this project indicates that:

1. Head Start had a positive influence in almost all (44 out of 47) of the changes investigated in depth.

> --A Head Start center in a northern industrial city was responsible for developing an after-school recreational activity program in some of the ghetto-area schools. Head Start staff and parents organized this program originally because of their realization that school-aged Head Start siblings had no place to play after school hours. At that time the program was held in the Head Start centers with parents alternating as volunteer supervisors. As the program gained in popularity in the poor neighborhoods, non-Head Start families became interested and Head Start staff requested that the school system take over the program so that it could be enlarged.
>
> --An innovative preventive-health-care project was initiated by a Head Start Policy Advisory Committee in a northeastern industrial city. The committee formed a consumer cooperative which purchases fresh fruits and vegetables in bulk, packages the goods, and distributes them to families in the ghetto. Much of the work involved in establishing this project was done by the Head Start parents themselves. All of the work involved in purchasing the goods, taking orders from families, and packaging and distributing the food is done by Head Start parents. Assistance in working out some of the technical details was provided by local university faculty members, but most of the credit for establishing this highly successful project belongs to the Head Start parents.
>
> --A health-care clinic in an eastern industrial city represents the culmination of many months' effort by Head Start parents, university medical students and faculty members, and the public health department. The concept for this clinic appears to have been the brainchild of Head Start parents and other members of the Head Start Parent Advisory Committee.

--The processes leading to curricular changes in a southern school system appear to have originated in a black PTA organization whose members found reason to criticize the content and relevance of classroom work. The parents requested a study of the curricula, which was conducted by professionals in the educational field and presented to the school system with recommendations for changes. These changes were subsequently implemented by the school system.

--Head Start parents in a western city allied themselves with local black activist groups to bring about specific changes they wanted in the school system. Head Start staff and delegate agency people organized parents and encouraged them to press for changes such as hiring Negro teacher aides and providing free hot lunches for needy children.

2. Communities without the Head Start experience had fewer and less marked changes in their educational and health institutions.

--In one small northern community, which has no Head Start, the prevailing general attitude was that the poor were no different from the more affluent--"just lazier." Private physicians alleged that the poor seemed able to afford everything except good medical care for their children, and that if these parents budgeted their money more efficiently, they could afford the health care their children needed.

In this conservative town, the general opinion reported was that each family should pay for what it receives, including medical care. No public health programs existed; nor was there a public health nurse, an immunization program, or a maternity or well-baby clinic.

--In a southern community, which has no Head Start program, a handful of dedicated persons was found to be working on educational and health problems, but with only partial success at best. One program, supported by a local Negro church, was designed for black preschool children. It was financed almost entirely by parents of the children who paid $1.50 per week for supplies and packed lunches for the children to take to the "school," located in the church building. The program was run entirely by the volunteer efforts of its two founders, an elderly

> retired black school teacher and a young black minister. It was apparently the only community involvement effort of the poor in this town, and the only educational program available to black preschool youngsters.

3. Factors other than Head Start were frequent, important contributors to institutional change during the period studied. One of these factors was the concurrent availability of Elementary and Secondary Education Act (ESEA) funds and other federal funds for programs to help the disadvantaged. In many cases where Head Start was instrumental in encouraging the institutional changes noted, the availability of these federal funds to local institutions was also crucial.

> --One of the best examples of successful attempts by Head Start to generate institutional change is provided by a school system in a predominantly black southern community which now operates a comprehensive health clinic. The clinic is financed almost entirely by federal funds. This school system has altered its traditional role of educator to include that of health-care provider as well. The idea for a health-care facility was generated by a Head Start nurse who realized the need for such a program after examining the Head Start enrollees, most of whom exhibited symptoms of chronic disease and malnutrition. Many had never been examined by a doctor. The nurse presented these facts to public health and school officials and requested their help in finding a solution to the problems. Together they worked out a plan whereby the school system would apply for federal funds to establish and operate a health clinic for children.

> --In a northern community an "Extended Kindergarten" program was developed for operation in two low-income area schools. Techniques and curricula used in the new program are based on the Head Start model. The school official responsible for originating this program reported that she had seen the need for it long ago, but had not been able to develop the program until federal funds became available.

Head Start's Role in the Process of Change

To move beyond the conclusion that Head Start has influenced local educational and health institutions, an effort was made to increase understanding of how this influence was generally exerted.

For purposes of this analysis, the process of institutional change has been divided into seven stages, each of which is described by example below:

1. Background Stage

--The school system began to concern itself with malnutrition of the poor children--a rather universal condition among the Head Start children that came to light during their physical examinations. School officials' awareness of this problem led them to apply for funds to implement hot meal and snack programs in the schools.

2. Idea - Proposal Stage

--The persistent efforts of one individual--a Head Start director--were reported to have been solely responsible for bringing about an enlargement of the health department's immunization program. A large proportion of the children who enrolled in Head Start had never had immunizations--a fact discovered during the children's Head Start physical examinations. This discovery instigated the Head Start director's campaign for an enlarged immunization program that would serve a greater number of children and include immunizations against smallpox, measles, and polio as well as the DPT series.

3. Support for Change Adoption

--In a western community, the large Spanish-American segment of the population had felt discrimination by the school system for many years. Furthermore, the Spanish-Americans felt that the school system's refusal to recognize and cooperate with Head Start was an example of its long-evidenced disinterest in educating Spanish-Americans. The Head Start parents allied themselves with other active minority-group organizations and together they campaigned for a slate of school board candidates who were sensitive to their problems. Their efforts were successful, and they were able to elect a majority of the school board.

4. Authorization Stage

--In a small southern town, the health department requested that it be allowed to administer the medical component of Head Start. The stated purposes behind this request were that it would enable the health department to centralize all records on the children and to have more contact with the parents. Although originally reluctant to approve the measure, OEO Regional officials authorized it after much negotiation and discussion with local Head Start and health personnel. The additional funds made it possible for the health department to hire additional staff members.

5. Resource - Fund Provision

--In a large midwestern city, the Head Start program provides training for paraprofessionals employed in various public health services.

6. Execution Stage

--Many of the kindergarten teachers in a large city school system in the West have modeled their classroom scheduling and programming after the Head Start program. Most of the kindergarten teachers who made these changes were former Head Start staff members who had successfully used the new, less rigid techniques with Head Start children. When these Head Start staff members became a part of the regular school system they took their ideas and methods with them.

7. Support During Change Execution

--Head Start children, siblings, and parents in the city are frequently referred by Head Start to the new health-care programs in the community for medical treatment, family planning consultation, dental care, prenatal care, and immunizations.

In 94 percent of the institutional changes studied, Head Start was involved in one or more stages of the change process. In a majority of the changes, Head Start was involved at three or more stages as indicated in Table S-2. It appears from these data that when Head Start was involved in the change process, its involvement tended to go beyond an intervention at only one point in time when one type of assistance was needed. A continuing involvement seems to be indicated.

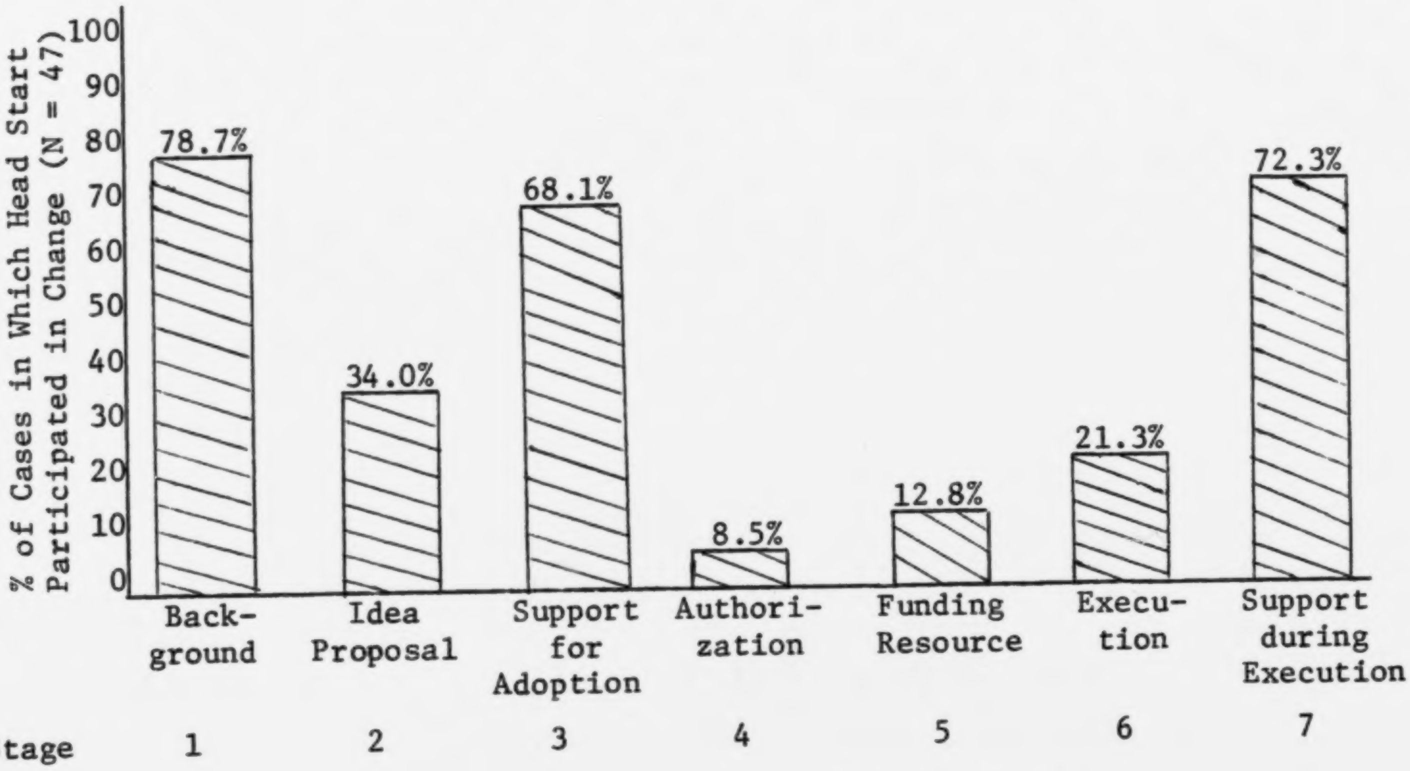
TABLE S-2

Frequency of Stages in Which Head Start was Involved in the Change Process

Number of Stages in Which Head Start was Involved		Number of Cases	
		f	%
None	0	3	6.4
	1	7	14.9
	2	10	21.3
	3	10	21.3
	4	10	21.3
	5	3	6.4
	6	1	2.0
All	7	3	6.4
Total		47	100.0

Graph S-1 illustrates the proportions of cases in which Head Start was involved at each of the seven stages. Head Start was frequently cited as a background factor (Stage 1) providing the community climate for change. In a number of cases the local Head Start program was given credit for having introduced new concepts into the community and demonstrating that these concepts were feasible and effective. When Head Start contributed to the background for change, it was found to have acted predominantly to focus community attention on a problem and increase the desire for its solution. In 82 percent of all cases, Head Start did this by serving as an example through its own efforts to solve a problem. In another 59 percent of the cases, Head Start attempted to create a psychological climate for change by intentionally stimulating community concern.

In over one-third of the cases, Head Start parents or staff members were responsible for proposing a change (Stage 2). Head Start staffs have demonstrated support for adoption and execution of changes (Stages 3 and 7) by such activities as assisting in the establishment of new programs and encouraging parents to take advantage of them.



GRAPH S-1: Head Start Participation at Each of Seven Stages of Change Process

In fulfilling its functions of supporting change adoption and cooperating during change execution, Head Start involvement was overwhelmingly that of an active participant. In at least 82 percent of all the cases, Head Start centers used direct, active methods to show their support for both change adoption and execution. In addition, during change execution Head Start often (in 50 percent of the cases) took advantage of its grass-roots contacts to encourage private individuals and groups to participate in the change. Thus the research data indicate that Head Start frequently played an active role in supporting change. Review of the case studies and the various accounts of Head Start's roles has revealed that Head Start generally had an impact on the institutional change process by pragmatic, quiet actions rather than by violent confrontation.

When the Head Start program has been highly involved in the change process (involved in at least 4 of the seven stages of change) the changes have generally been more positive and of more benefit to the poor than when Head Start was not involved or when it was involved minimally. Three cases, dealing with the same type of change, illustrate this point. The first case shows how a teacher aide program was modified so greatly that poor people could not be employed in it.

> --In a community without a Head Start program public school teachers demanded that the local system hire teacher aides to relieve them of some of their work. The administration and school board were quite willing to go along. State funds were available to finance the aide program and it began during the school year following the negotiations.
>
> At first, widespread satisfaction was expressed over the new aides: the school system saw the program as a solution for its own pressing problems; the low-income community regarded it as a measure that would provide jobs for its people. After a while, however, the program was modified and job descriptions rewritten so that only aides with a level of education well beyond that of most poor persons could be hired. The more stringent qualifications for aide positions could be met only by well-educated, highly motivated, middle-class persons who served as assistant teachers. The poor, few of whom could meet these new qualifications, were, in nearly every case, effectively barred from getting jobs as aides.

Head Start was involved to a minimal degree in the development of another teacher aide program.

--Teacher aides were hired in a southern school system the year that the schools were integrated. Aides were employed mainly for the purpose of doing the extra clerical work that was involved in transferring students' records from black to white schools. Head Start had demonstrated that employment of low-income black people was effective and inexpensive, and, following the example of Head Start, some were employed as aides by the school system. The following year, less money was available for paying teacher aides' salaries, and some of the aides had to be dismissed. It was reported that those who were dismissed were the low-income black people.

A teacher aide program in which Head Start was highly involved developed along strikingly different lines.

--The idea of having aides was proposed by public school teachers who had taught in a local Head Start program. Individuals selected as aides came from the neighborhoods where the schools were located. Thus, teacher aides in the low-income-area schools were low-income people.

School administrators reported that the aides were responsible for a number of positive impacts on low-income children and their parents. A noticeable improvement in the children's motivation and incentive to learn was reported, and the aides appeared to have been more successful than regular teachers in communicating with low-income parents. As a result of the success of the aide program, further changes were being contemplated; school officials had applied for funds to hire community aides from low-income areas to visit in the homes of students and further strengthen the link between the classrooms and impoverished homes.

The impacts of Head Start on institutions did not appear to differ significantly if the local Head Start operation was delegated to a public school system or to a new agency.

--An eastern school system began to employ paraprofessionals as teachers' assistants after public school teachers requested them. The teachers who made these requests had taken leaves of absence from the school system and taught in the CAA-delegated Head Start program where they had gained experience in working with paraprofessionals.

> --A school system in a small southwestern town developed a concern for the health needs of poor children as a result of its being delegated to operate the local Head Start. Poor health and nutritional conditions of the Head Start youngsters were discovered during physical examinations performed on the children. School officials realized at that point that local poor families were not utilizing available health facilities and that few of these people visited doctors except when very seriously ill. Subsequently, the school system applied for and received federal funds to hire a school nurse and four nurse's aides. The objective of the nursing program was to identify health problems of school children, notify parents, and insure that cases were followed up.

Certain characteristics of Head Start and the local communities were frequently associated with a high degree of Head Start involvement in change. These characteristics are itemized and defined by example below.

1. A high level of parent participation in the Head Start program, (defined as a high ratio of nonprofessional to professional staff and parental control over the selection of staff members). The examples below typify change processes, first, where "high" parent participation Head Start centers were involved and, second, where the Head Start parent participation level was classified as "low" according to the study's criteria.

> --An active Head Start parent group in the Northeast had generated the idea that stimulated the process of setting up a new health clinic.

> --In a small midwestern town Head Start parents have little responsibility in the program, and the program appears to be oriented toward providing services rather than organizing parents for community action. A few tangible changes have occurred recently in the delivery of health services (e.g., hours have been changed for the convenience of working people, and service clubs furnish eyeglasses). Head Start roles in bringing about these changes were primarily supportive. For example, the most conclusive evidence of Head Start's participation in these changes was at the final stage (support during change execution), where Head Start was reported to have encouraged families to use the new services.

2. A high degree of visibility of the Head Start program and a willingness by Head Start to relate to other local agencies and institutions.

> --In a western city Head Start programs and methods were well known, and its problems with the school system became public issues important enough to stimulate public action and result in fundamental changes in the school system.

In contrast:

> --A Head Start program in the South has reportedly elected to remain uninvolved with the outside community and channel its efforts entirely into programs for the children. In this community changes have occurred, but the evidence strongly indicated that Head Start had not been involved with any of them.

3. A community climate conducive to change, which in many cases seems to have been brought about by the combination of civil rights activities, the interest and influence of community and professional leaders, and the availability of federal and state funds to meet the needs of poor children.

> --An eastern metropolitan school system has responded to requests from civil rights groups for better educational opportunities. The school system has developed a community schools program which operates in the city's ghettos for people of all ages. This program, particularly the preschool component, is modeled after Head Start and encompasses much of the Head Start theory--employing teacher aides, involving poor people in decision-making, etc. The community school program is financed almost entirely with federal funds.

On the other hand:

> --School officials in a small southern, tradition-oriented community had continuously resisted the use of federal funds and the federal "interference" they felt would accompany them. Since the local school districts could not finance new programs without outside assistance, few if any changes had occurred.

CONCLUSIONS

To appreciate fully the significance of the changes in educational and health institutions noted above, one must view them in perspective. Education and health have traditionally been provinces of professionals, who, somewhat aloof from public contact and control, have protected, taught and disseminated middle-class values for the benefit of middle-class families. In the brief period of less than half a decade, concurrent with the life of Head Start, these institutions have changed remarkably. They have become concerned with the needs and the problems of the poor and of the minorities and have manifested this concern by revising curricula, schedules, approaches, services, etc. They have increasingly involved the public, including the poor, in positions of influence, and they have changed employment criteria so that neighborhood people without professional credentials occupy important paraprofessional positions.

One can truly say that these institutions are still not fully responsive to the poor, that the local commitment to change has not been backed by local dollars, and that the available educational and medical technology is not adequate to the needs. But one cannot deny that in a short time, with a relatively small investment, Head Start has been closely associated on a national basis with the development of fundamental changes in educational and health institutions, two of the most crucial institutional groups in the country. Head Start has been a successful strategy in that it has widely achieved its goals of modifying local institutions so they are more responsive to the needs and desires of the poor.

CHAPTER I

INTRODUCTION

OBJECTIVES OF THIS PROJECT

Project Head Start has a number of goals designed to improve the opportunities and achievements of the children of the poor. These goals have been stated as follows:[1]

> --Improving the child's physical health and physical abilities.
>
> --Helping the emotional and social development of the child by encouraging self-confidence, spontaneity, curiosity, and self-discipline.
>
> --Establishing patterns and expectations of success for the child which will create a climate of confidence for his future learning efforts.
>
> --Increasing the child's capacity to relate positively to family members and others while at the same time strengthening the family's ability to relate positively to the child and his problems.
>
> --Developing in the child and his family a responsible attitude toward society, and fostering constructive opportunities for society to work together with the poor in solving their problems.
>
> --Increasing the sense of dignity and self-worth within the child and his family.

Most research concerning Head Start has focused on determining how successful the program has been in helping children with whom it works. Other research projects have also focused on related matters that tend to be within the direct control of Head Start, such as program curricula and teacher training.

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[1] Report prepared for the Office of Economic Opportunity by a Panel of Authorities on Child Development, Robert Cooke, Chairman. 1964 GP 923-454.

It must be recognized that Head Start is also vitally concerned with influencing the environment in ways deemed beneficial to the children of low-income families. This is inferred from many of the Head Start goals noted above which cannot be accomplished solely as a result of the association of a child or his family with Head Start. For these goals to be achieved it is obviously necessary that the philosophies, practices, and activities of other community institutions become more sensitive and responsive to the needs of the poor and their children. Indeed, it is evident that one of the primary Head Start objectives is to modify existing institutional policies and programs that are deemed counter to or inconsistent with the achievement of Head Start goals. The research effort described in this report deals with this aspect of Head Start, i.e., the impacts of Head Start on the community and particularly selected crucial community institutions.

It can be expected that the longer Head Start, or any new program, operates in a community, the greater influence it will have on that community. Thus the length of Head Start's tenure in the community will probably make a difference in the nature and strength of its impacts on that community. It is important to note that field work on this study was initiated in the late fall of 1968 when full-year Head Start programs were approximately one year old. However, most of the full-year Head Start programs in the sample communities had been preceded for two or three years by summer programs.

More specifically, the objectives of the research project described in this report are as follows:

1. To determine if there have been widespread changes in local educational and health institutions consistent with the philosophy, policies, and programs of Project Head Start;

2. To determine if local Head Start centers were influential in bringing about relevant changes in community institutions;

3. To analyze how Head Start was involved in the institutional change process;

4. To describe the different impacts on community institutions of various Head Start characteristics and approaches.

This project attempts to obtain a greater understanding of Head Start's role in influencing changes in community institutions. More broadly, it is hoped that it will illuminate the general question of how to achieve changes in local institutions utilizing a nationwide educational innovation as the intervention strategy. To the extent that these objectives are achieved, it permits the design of Head Start and other intervention programs to be more effective in achieving their goals of modifying local environments.

LIMITATIONS OF THE PROJECT

General

As indicated immediately above, the principal objective of this project is to understand better the impacts of Head Start on selected local institutions. The project was not designed to determine all of the impacts of Head Start. Therefore, consideration is not given to all of the possible changes it may have caused in institutions, in attitudes or in the children themselves. The research is concerned principally with tangible changes in the way educational and health institutions operate as they relate to the poor.

It is recognized that many forces in addition to Head Start could have influenced local institutions. It was not intended, however, to examine the effects of these other forces in as much depth as the effects attributable to Head Start itself. Neither was it intended to examine the influence that personality traits and private motivations may have had. Last, this is not an evaluation of how well any Head Start center in particular has performed in behalf of the poor, their children, or the communities in which they operate.

Specific

The retrospective nature of this project presents certain limitations when examining institutional change. With this type of approach it is not possible to set up hypotheses prior to the advent of change and then to attempt to observe and measure the change. The possibility of manipulation or control of variables is not possible in such an ex post facto study.

This particular study has had to rely principally on information from persons "most likely" to know about or to have been involved in the change. This type of data collection approach also has to face the possibility that pertinent source people are not available to be interviewed. Nevertheless, the nature and patterns of relationships found, while not ironclad, do suggest that some concepts and explanations are more reasonable than others.

The interviews consisted largely of open-ended questions which were employed by the field staff in pursuing the causes of changes that had been identified. Some of the questions in the interview schedules elicited information based on the respondent's personal judgment, which could be classed as highly subjective. Also, much of the information elicited was based on the recall of respondents who may have inadvertently provided inaccurate data. However, since several persons were asked for the same information, it was possible to obtain consensual validation, or cross-checking. However, despite attempts to minimize the effects of bias and inaccuracy of respondent recall, no doubt some still remain. Therefore, the analysis of these interviews supplies suggestive answers to questions about causality.

The next chapter (Research Plan) reviews the strategy and methodology utilized in this project. Subsequent chapters then present the findings and conclusions that were developed as a result of this research project.

CHAPTER II

THE RESEARCH PLAN

INTRODUCTION

This project approached an inherently difficult task--that of determining Head Start's contribution to changes in local health and educational institutions. To do this it was necessary to identify and trace, in retrospect, complex networks of events that were closely intertwined with community social structures. Design and data collection issues and procedures to accomplish such a task are complex. These are discussed in this chapter, and many of the subsequent chapters of the report contain sections dealing with the methodology particularly pertinent to their subject matter.

It is also appropriate to realize that existing social science methodology is not sophisticated in the area of attributing a social change to a particular variable or group of variables. Thus, it was not possible to select from a number of effective research procedures one particularly suited to the goals of this endeavor. It was necessary, instead, to attempt to create a design that would relate institutional change to Head Start (and to its various characteristics) in more sensitive and reliable ways than heretofore available. This section describes how the research plan was conceived, evolved, and implemented.

RESEARCH STRATEGY

The research strategy for this project evolved as a result of discussions and review meetings involving our own staff, consultants, members of the Head Start research staff, and members of the Head Start Research Advisory Committee. The following paragraphs review a number of the crucial project design decisions.

The Initial Proposal

The original proposal for this project contains a series of hypotheses relating Head Start and community characteristics to impacts on community institutions. These hypotheses were to be tested utilizing data from transactional interviews and other information-collection techniques in sixty communities. Fundamentally, this research design remained unchanged. Although there were certain modifications and refinements of the research procedures. During the process of refinement, it became apparent that the initial hypotheses cited in the proposal involved an impracticably large number of community and Head Start variables. With this quantity of variables it would have been statistically difficult, if not impossible, to develop meaningful relationships between the independent and dependent variables within the proposed sample size and allotted level of effort. Consequently, it was decided to limit the study's focus to institutions that are associated most closely with Head Start's goals and programs (i.e., public educational and health institutions). Indeed, it was reasoned that if impacts of Head Start were not found in these critical and Head Start-related institutions, it was not likely that there would be other significant changes in a community that could be attributed to the intervention of Head Start.

Definition of Community Impact

For purposes of this project, the community impacts of Head Start were defined to mean changes in selected community institutions (educational and health) that could be attributed to Head Start. Consideration was given to the possibility of including as impacts changes in the attitudes, perceptions, and behaviors of people within various community organizations. In addition to examining changes in school board policies, for instance, changes in attitudes of first grade teachers could be investigated. That type of inquiry was not included because it was decided jointly (by Head Start officials and the contractor) that there were not sufficient resources to accomplish both an investigation of institutional changes and of changes in attitudes of the members of institutions. This latter area was not regarded as unimportant but as the possible subject for another related project.

The Research Strategy

At the outset of the project there was obviously no assurance that institutions had changed in ways that might reasonably be attributed to Head Start. Therefore, it was concluded that the first research step must be to determine if such institutional change had occurred. Then, if the answer was positive, methods of attempting to attribute them to causal factors could be undertaken.

In keeping with this strategy, a preliminary telephone interview program was undertaken. This informal program had as its principal goal determining whether or not changes of types presumed to be related to Head Start had occurred in various communities throughout the country, or if other types of changes seemed to be more prevalent.

Once the informal telephone inquiries indicated the widespread existence of relevant institutional changes, it was feasible to proceed to the next step. The next step (Phase I) was designed to determine on a systematic basis what relevant institutional changes had occurred. This stage of the research program was also designed to determine if there seemed to be relationships between institutional changes and particular Head Start and community characteristics (independent variables). It was reasoned that it was important to determine systematically if relevant changes had occurred and if they seemed particularly related to any variables before doing an intensive investigation of the change processes. If relevant changes had not been widely identified, the subsequent phase of the research would have been very different.

Since relevant changes were widely identified, the last aspect of the strategy (Phase II) called for an intensive investigation of selected changes to determine if and how they might have involved Head Start. This effort was designed principally as an anthropologicalsociological inquiry focusing on the details of the change process. Thus, the overall strategy involved reliable and systematic identification of relevant changes and the use of two methods (statistical and anthropological study of processes) to determine if the changes could be attributed to Head Start, to particular activities and characteristics of Head Start, and to certain factors in its community environment.

An Experimental-Control Strategy

Consideration was given to the possibility of utilizing two matched samples of cities equivalent on as many variables as possible (size, percentage of population in poverty, etc.) with one group (experimentals) having Head Start centers and one (controls) not having Head Start. In reality, the use of control communities was not feasible because of the near impossibility of finding communities without a Head Start experience and because non-Head Start communities that were found were viewed as quite atypical. A subsequent section of this report discusses the findings from the seven comparison communities where inquiries were conducted.

PRELIMINARY INQUIRY PHASE

Purpose of Inquiries

As indicated in the previous section on Research Strategy, a preliminary series of interviews was conducted early in the project. These interviews were designed to provide indicators of (1) whether local institutions had changed in ways related to the goals of Head Start, and (2) what changes appeared to knowledgeable observers to be impacts of Head Start. Another important purpose of this informal survey was to foreclose the unlikely possibility that there were no relevant changes--a situation that would have required a reassessment of project goals.

Interview Respondents

To satisfy the purposes of the interviews, it was important to select interview respondents who were aware of Head Start and community activities and had the ability to analyze complex local situations. Personnel at the national Head Start headquarters selected individuals who had served during a period of three years as consultants to various Head Start programs. Twenty-three consultants were contacted by letter (see Appendix A) and told of the nature of this research project and the types of data sought. Twelve indicated that they would be interested in participating in this research. In addition to the Head Start consultants, KAI interviewed a number of persons who had participated in this firm's previous studies of Community Action Program impacts and/or were presently involved in CAA or Head Start research. The total group of persons interviewed during this preliminary phase was comprised primarily of professionals in various social science fields who were members of university and college faculties. The majority were at the Ph.D. level or were Ph.D. candidates at the time of the survey.

Interview Procedure

As indicated above, each of the potential respondents was contacted by a letter which included a brief description of the project and the questions they would be asked. All of these interviews were conducted by telephone by two professionals of KAI's central staff. Twenty-two interviews were carried out during this phase of the project.

Two alternative instruments were initially devised for use as a telephone interview guide. One of these instruments was highly structured and sought data on specific areas within a variety of community institutions. The second interview schedule was less structured and was intended to elicit two or three concrete examples of Head Start's effects on local institutions. It also asked for the respondent's judgment as to whether the specified changes were confined to a particular community or whether, in fact, the change was of a type that had been observed in a number of communities with Head Start programs. Preliminary testing of the instruments revealed that the less structured guide elicited more information.[1]

Interview Results

All of the respondents reported one or more incidents of community change that they felt were directly or indirectly attributable to Head Start. Direct impacts were reported most consistently in elementary schools and in health institutions, with some changes also reported in other institutions.

The types of changes mentioned most frequently with respect to educational institutions included trends toward decentralization, increased use of indigenous neighborhood residents in paraprofessional positions, modifications of curricula to make them more sensitive to minority group cultures and history, modifications of curricula derived from Head Start experiences, improved facilities, and decreases in student-teacher ratios.

In the health area, reports indicated that Head Start families had begun increasingly to seek out and demand more health care because they had learned the location of facilities, the types of services available, and the value of such services. This placed severe pressures on health facilities and often caused authorities to modify delivery systems to improve service.

Other possible influences of Head Start were also reported. Changes in curricula of teachers colleges and universities to deal more effectively with problems of poor children were in a few cases attributed to Head Start. Also, certain private community institutions were more involved in poverty areas, particularly with children.

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[1] See Appendix B for interview guide.

The evidence suggested that the greatest changes had come in those institutions most directly associated with Head Start. For instance, it was reported that a full-year Head Start classroom located in a public school prompted other teachers to create pressures to have fewer students and also to redesign curricula for better continuity between Head Start and the elementary schools. It also appeared that dental and medical association members involved with Head Start health components had grown more receptive to caring for Medicaid patients than had their noninvolved colleagues.

PHASE I RESEARCH

Purpose of Phase I Research

Phase I of the nationwide research program was conducted in a sample of 58 communities and was designed to identify systematically institutional changes that might be attributable to Head Start. Additionally, it was hoped that if changes were identified, they could be related to selected Head Start or community characteristics.

Sample Selection

Selection of sample communities was based upon the hypothesis that Head Start impacts may be related to (1) the kind of agency to which the Head Start program is delegated, (2) the extent of parental and neighborhood involvement in the Head Start program, (3) the ethnicity of the Head Start clientele, and (4) the size of the community. The sample communities were selected from a list of 485 communities supplied by Head Start about which information on the four variables above was thought to be readily obtainable. The effort was made to obtain as much variety as possible considering these four variables. This information was secured from the results of a Bureau of the Census Survey of Head Start Centers during 1967-68. The instrument used to obtain these data was entitled "Center Facilities and Resources Inventory," CAP-HS-52, and is shown in Appendix C.

In order to examine the relevance of the nature of the Head Start delegate agency to institutional changes, it was decided to select communities with the three most prevalent types of Head Start delegate agencies. These were: (1) public school systems; (2) "new" agencies, such as local community action agencies, neighborhood organizations, or single-purpose agencies; and (3) "traditional" agencies, such as social service institutions, settlement houses, and churches.

In order to assess the relationship between parental participation in Head Start and Head Start's impacts on institutions, it was desired to select communities with a wide range of participation levels. Information on community and parental involvement was obtained from two indices in the 1967-68 Bureau of the Census survey instrument concerning the professional-nonprofessional ratio of staff members and the extent to which Head Start staff was selected by Head Start parents. Appendix D describes in detail how levels of parent participation were developed.

It has been observed that various ethnic groups differ in the extent of their community participation, demands made upon community institutions, and institutional responses to these demands. Thus, it was hypothesized that the nature of institutional changes might in part be functions of the dominant ethnicity of the local poverty population and, correspondingly, of the Head Start clientele. To insure that this variable was given adequate consideration during the research project, the sample was constructed so that Negro, Spanish-American, and Anglo poverty (or Head Start) populations would be represented. Data on the predominant ethnicity of Head Start clienteles were obtained from the "Center Facilities and Resources Inventory," Part II, Item E.

Variations in community size were hypothesized to have some relationships to the nature and extent of Head Start's impacts on schools and health agencies. The sample was designed to include communities in three population size categories: large--100,000 and over; medium-sized--between 25,000 and 99,999; and small--under 25,000. These data were obtained by the "Center Facilities and Resources Inventory," Part II, Item C.

The sample was designed so that the communities to be surveyed would represent, to the extent possible, the full variety (81 different combinations) of the four variables. Table 1 indicates the communities selected and their characteristics. This sample was not designed to be proportionately representative of the universe with respect to these variables. Appendix E describes the development of the sample. Tables included in this appendix show the characteristics of the universe and the sample based on Census Bureau information.

Field Research Instruments

The initial field research effort was conducted to determine the nature of changes that had occurred in school systems and health agencies since the inception of the respective local Head Start programs. To obtain these data from respondents in 58 communities, a comprehensive survey instrument was designed.[1] The questionnaire contained both precoded and open-ended questions. Before utilizing the instruments on a national basis, they were pretested in seven communities of various sizes located throughout the country. The pretest was accomplished by KAI central staff members as well as by university-associated field research associates.

The pretests resulted in recommendations of remarkable uniformity among interviewers with respect to administration of the instrument. Most of the consequent revisions concerned procedural matters rather than significant substantive issues. The instrument in Appendix F represents the final version.

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[1] See Appendix F.

TABLE 1

CHARACTERISTICS OF HEAD START COMMUNITIES
REVISED DATA

PHASE 1 SAMPLE

		"HIGH" PARTICIPATION			"MEDIUM" PARTICIPATION			"LOW" PARTICIPATION			Tot.
		SPANISH	ANGLO	NEGRO	SPANISH	ANGLO	NEGRO	SPANISH	ANGLO	NEGRO	
Large Cities	Public School		Providence, R.I.			Knoxville, Tenn.	Detroit, Mich. Toledo, Ohio			Compton, Calif. Akron, Ohio Omaha, Nebr. Silver Spgs., Md Baltimore, Md. Portland, Ore.	10
	Trad. Agency			Buffalo, N.Y. Yonkers, N.Y.							2
	New Agency						Milwaukee, Wisc.			Wash., D.C.	2
	Mixed Agency	Denver, Colo.		Long Beach, Calif.			Chicago, Ill.	Riverside, Calif.			3
Small Cities	Public School		Elkhorn City, Ky.	Newton, Miss.	W.Las Veg.,N.M. E.Las Veg.,N.M. Rancho de Taos, N.M.			Perris, Calif.		Tuskegee, Ala.	7
	Trad. Agency			Greenwood, Miss.		Springfield, Vermont	Pontotoc,Miss.				3
	New Agency		Poteau, Ok. Russellville& Ozark, Ark.	Melbourne, Fla. Gainesville, Ga.		Pittsburg, Ks. Woodbridge,N.J. Bentonville,Ark			Marshall,Mo. Speedwell,Tenn Mitchell,S.D.	Ville Platte, La.	12
Medium-Sized Cities	Public School					Manchester, Conn.	Newburgh, N.Y. Lexington, Ky.		Provo, Utah	Hamilton, Ohio	5
	Trad. Agency			Galveston, Texas							1
	New Agency	Pueblo, Colo.	Pittsfield, Mass.	N.Brunswick,N.J. Florence, S.C. Greenville,Miss		Burlington, Iowa	Joliet, Ill.		Fond du Lac, Wisc. Kingsport,Tenn	Beloit, Wis. Atlantic City, N.J.	11
	Mixed Agency		Bangor, Maine								1
TOTALS		2	7	11	3	7	8	2	7	11	58

Survey Respondents

Based partially upon the findings of the preliminary telephone interviews that Head Start impacts were most strongly felt in health and educational institutions, it was decided to concentrate on identifying the frequency and nature of changes within these institutions during the initial research phase. Therefore, respondents selected were individuals who would be the most knowledgeable about activities in these two kinds of institutions. The interview instruments were thus addressed to individuals filling these positions:

Superintendent of public school systems
Board of education presidents
Principals of poverty area elementary schools
Directors of public maternal and child health-care programs
Directors of public health departments
Representatives of private medical and dental associations
Community Action Agency (CAA) directors
CAA Head Start directors
Delegate agency Head Start program directors

In addition, field research staffs were encouraged to conduct interviews with other local individuals having knowledge of changes in health and educational institutions, and to make substitutions in the list of respondents as deemed appropriate in view of respondents' availability and knowledge of the subjects to be pursued. For ease of administration, questionnaire items were organized into three series of instruments: one for health-related respondents, one for public school personnel, and one for CAA and Head Start personnel. This was done so that questions could be addressed to appropriate respondents, with health-related questions addressed only to health-care personnel and education-related questions addressed to school-system respondents. The CAA instruments incorporated all questionnaire items from both the health and school instruments.

Within two of the instruments--those for CAA and public school respondents--some of the questions were restricted to certain categories or levels of respondents. The purpose of this procedure was to insure that all questions would be directed toward respondents having the greatest knowledge of the subject matter. Questions pertaining to the entire school system, for example, were directed only to top-echelon administrative personnel. Questions concerning neighborhood schools were reserved for interviews with school principals.

Appendix G presents a discussion of the characteristics of all respondents interviewed in Phase I with respect to position, age, ethnicity and sex, and length of time in present position. These figures are presented in terms of the type of instrument (i.e., school, health, or CAA) used during the interview.

The list of respondents actually interviewed adheres very closely to that planned in the research design, with about sixty percent of the interviews being conducted with top-echelon and program officials of the three areas--health, education, and CAA. Also, in accordance with design specifications, a significant proportion of other respondents was included; e.g., public maternal and child health nurses, private physicians and dentists, and public school principals. A small proportion (thirteen percent) of the interviews were conducted with individuals not specifically enumerated in the project design or instructions to interviewers but who nevertheless possessed highly relevant information. These respondents included, among others, CAA health and dental directors, school nurses and poverty-area elementary teachers, and public school administrative personnel in charge of curriculum and health. Field research staff members selected these respondents for interview because of their knowledge of local institutional changes.

Treatment of Data

The principal, though not the sole, purposes of the first phase were to determine if relevant institutional changes had occurred and to get some idea of their main types. Consequently, the data were also analyzed in terms of the number of different institutional changes identified.

A great variety of analyses were undertaken in attempting to relate independent and dependent variables. A brief description of the procedures utilized during this effort is presented in Appendix H. Although much effort was devoted to this phase of the analysis, it was subsequently determined that it had not been productive and the results are not presented, although they are available. A number of factors resulted in this decision. First, most of the analyses were conducted utilizing the number of responses, not the number of changes, as the dependent variable. This proved to misrepresent actual conditions. Second, the Phase I field work was principally to identify changes but not to explore them in depth. As planned, this effort did succeed in identifying changes; however, enough information about each change was obtained to make the analysis of their relationships to independent variables meaningful.

Various sections of the Phase I interview schedules were designed to facilitate coding and compiling reported changes. These sections consisted of "lists" of services, programs, and personnel, or other aspects of health and educational institutions that might have represented a change at the local level. The lists were presented to interview respondents, who were asked simply to indicate whether or not the changes represented on the lists had occurred locally. It was from these sections of the questionnaires that much of our information about the frequency of institutional change was derived.

Sections of the Phase I instruments used for tabulation included:

--Health instrument, page H-12.

--CAA instrument, page C-25.

--School system instrument, pages S-14 through S-20.

--CAA instrument, pages C-17 through C-20.

In addition to the listed changes, two other questionnaire items were utilized for tabulating changes following Phase I. These items dealt with employment of paraprofessionals in public schools and involvement of the poor in decisions pertaining to changes made by health institutions. Data on these two items were elicited by the following questions:

> "Does the public school system have paid teachers' aides helping in the classrooms...?" (School instrument, pages S-12; CAA instrument, page C-15), and
>
> "Have the poor been involved in...decisions with respect to...changes in...health services and facilities?" (Health instrument, page H-13; CAA instrument, page C-26).

Responses from the lists and the two items above were coded by community onto a master sheet. A specific questionnaire item was recorded only once for each community regardless of the number of respondents who mentioned it. By virtue of the fact that a particular type of change was counted only once for each community, there is a strong possibility that the quantity and magnitude of the changes have been underestimated in this analysis. This is particularly true of the changes in the larger cities, where several distinct but similar types of new services could have been reported. If the changes were very similar they would have been recorded by the interviewer under the same item. Thus a recorded change might have encompassed more than one distinct change in a community. Further, when several respondents reported the same type of change, it was counted as only one change. However, it is possible that each respondent could have been referring to a different instance of a similar type of change.

During the coding process caution was exercised in an attempt to record changes that appeared to be valid; i.e., changes that had indeed taken place and had taken place since the inception of the local Head Start programs. Interview responses occasionally were found to be inconsistent with other information and contradictory to statements of other respondents. When confronted with information such as this, attempts were made to validate or document the findings. This was done by the field research associate at the local level or by central office staff. In the latter case it was necessary for coders to attempt to arrive at an independent judgment based on all data available. Insofar as possible, effort was expended not only to code data accurately but to insure the validity of information before coding.

After all selected questionnaire items from the 58 communities were coded onto the master sheets as changes, they were tabulated first by community and then by type of change. These separate tabulations produced a total of all institutional changes coded as well as a cross-check of the separate tabulations. Information thus obtained provided the base for a frequency distribution showing the number of communities with various frequencies of reported changes.

Changes were also classified into change areas--health and education--and into four change categories (listed subsequently). Each change was classified into the health or education area without regard to the type of institution making the change. Thus, some changes placed into the health area were actually made by educational institutions. (There were no reports that any educational changes were made by health institutions.) Tabulations were made of the number of changes in each change area in each community. Proportions of health to educational changes in each community were then calculated, so that it could be determined what proportion of the total changes were in the health area and what proportion were educational--in the total sample and in each community.

Four categories of change were selected. Each questionnaire item utilized during these calculations was placed into one of the four categories. The four categories are listed below. A list of questionnaire items placed in each category may be found in Appendix I.

1. Increased involvement of the poor with institutions, particularly at decision-making levels and in decision-making capacities.

2. Greater employment of local persons in paraprofessional educational occupations.

3. Greater educational emphasis on the particular needs of the poor and minorities.

4. Modification of health services and practices to serve the poor more effectively.

A frequency distribution was prepared that would show the number of change categories in each community. This calculation revealed that all communities had experienced at least three categories of change; 87 percent of the communities had changes in four categories.

The various analyses described above were found to be more productive than attempts to relate independent and dependent variables. Descriptive results of the Phase I analysis are presented in Chapter III.

PHASE II RESEARCH

Purpose of Phase II Research

During Phase I, efforts were made to determine whether or not relevant changes in school systems and health services had occurred since the inception of local Head Start programs. The Phase II program was designed to determine how changes identified in Phase I developed and what relationships Head Start had to these changes. Thus, it was necessary to study the Phase I results and determine what changes had occurred in a substantial number of the sample communities.

Sample Selection

Resource limitations precluded investigating in depth all of the communities and changes identified in Phase I. A sample of these communities was selected utilizing the procedures indicated in Appendix J.

After the Phase I data were processed, changes found were classified and selected for intensive study during Phase II. Four major impact or change categories were found to exist, and these are listed on the previous page. For purposes of study during the second phase it was necessary to subdivide two categories. Thus, there were six categories from which the Phase II changes were selected. One category and one alternative were assigned for intensive study in each community. The six categories were:

1. Increase or decrease in health services available to the poor.

2. Increased or decreased involvement of the poor in the decisions about changes in health facilities and services available to the poor.

3. Changes in school curricula, programs, and facilities reflecting increased or decreased concern with early childhood education and the primary grades.

4. Changes in school curricula, programs, and personnel reflecting increased or decreased concern for educational needs of low-income and minority-group children.

5. Employment of teacher aides, or an increase or decrease in the number of teacher aides employed.

6. Increased or decreased involvement of the poor in decisions about changes in the public schools.

Because of the small numbers of institutional changes which were being investigated during Phase II, it was not feasible to to analyze them within the six categories above. Therefore, the analysis of Phase II data combined the subparts above into health (Items 1 and 2) and education (Items 3, 4, 5, and 6) categories.

The change assigned for study during Phase II in each community was based on the most prominent one identified in the Phase I interviews. (See Appendix Table J-2 for distribution of changes.)

Field Research Instruments

Instruments for the Phase II field work were constructed by the Project Director and the specialists who had designed the Phase I instruments. These are presented in Appendix K.

The Phase II instruments were designed to elicit information on how a specific change or changes developed and what role, if any, Head Start played during these developments. Because of intercommunity differences in educational and health changes, environmental factors, and individuals and organizations involved in the changes, it was not appropriate to employ structured questionnaires. Instead, the KAI field research staff was supplied with general guidelines for obtaining specific categories of information. Within each category a set of suggested topics was presented for use during the interviews. All topics were to be covered unless the interviewer determined, after questioning respondents, that they were not applicable to the local situation. The instruments were field tested in geographically dispersed communities.

Survey Respondents

The objective of the Phase II interviews was to illuminate the nature of transactions which had led to institutional change and to determine whether and how Head Start had been involved. In order to satisfy these objectives, it was necessary to outline at least the history of transactions leading to change by talking with individuals who had been involved at various points and by corroborating the findings with all available individuals central to the changes being studied.

Field research staffs in each community were instructed to interview CAA and Head Start directors and individuals who had participated in bringing about the changes. Consequently, the list of respondents varied from community to community and had to be left to the judgment of the interviewers. A change made by a school system, for example, might require interviews with the school superintendent, a school board member, principals and teachers in poverty-area schools, the Head Start director, and leaders of militant minority group organizations who had worked on behalf of the change. To provide another example, if a change in a health agency was requested by a Head Start nurse, respondents would include, among others, involved health officials and the Head Start director and nurse.

Approximately two-thirds of the changes studied were in education; the remaining third were in the health area. The distribution of respondents representing these institutions corresponds quite closely to areas of change, with about two-thirds of the respondents representing school systems and one-third public and private health agencies. Appendix Table L-1 shows the proportions of respondents representing the various institutions. Forty-one percent of all Phase II respondents represented CAA's and Head Start programs; 54 percent represented educational and health institutions. The remaining five percent of the interviewees consisted of a miscellany of individuals including chamber of commerce personnel, welfare department staff members, newspaper people, and individuals affiliated with civil rights groups.

The statistics presented above represent only those respondents with whom complete interviews were conducted. An extensive number of individuals were called upon for specific items of information, and were not asked to respond to all subject areas in the interview guide. These partial interviews were generally conducted when it was necessary to verify information offered by other respondents or when it was indicated that a respondent would not be a reliable source of information in all the subject areas covered by Forms B and C.

Over 300 full-scale interviews were conducted in the 42 communities. Table L-2 presents information on the characteristics of respondents to these interviews. These data indicate that there is a great deal of similarity between Phase I and Phase II respondents with respect to ethnic and sex characteristics and agency affiliation. It is noted that the majority of health agency and school system respondents were white males. Respondents in CAA's and Head Start programs were about evenly distributed between blacks and whites, and men and women.

With respect to age, there also are similarities between respondents in the two phases. Youth is reflected in far greater proportions among Head Start and CAA respondents than among those in school systems and health agencies. Fifty-five percent of the Head Start and CAA respondents were under forty years of age, whereas only 34 percent of the school and health respondents were in this age group. A typical respondent representing a school system or health agency was a white male between forty-one and fifty years of age, while a spokesman from a CAA or Head Start program was likely to be under forty, female and black.

Treatment of Data

Each of the Chapters IV, V, VI, and VII based on the Phase II field work includes a brief methodological section appropriate to the material being discussed.

Two principal data treatment approaches were employed. First, the case study materials were reviewed intensively by staff members in efforts to develop qualitative analyses and conclusions. Very simple coding systems were utilized in this data treatment approach and principal reliance was placed on organization of examples to illustrate generalizations drawn from the analysis of the individual case studies.

Phase II interview schedules did not have detailed question-and-answer format, but instead consisted of an Interview Guide and Reporting Form, as indicated in Appendix K, containing an outline of general areas and specific topics to be covered by probes and questions. For each change investigated, a number of respondents were interviewed, starting with those identifying the change being investigated. From the group of interviews, the interviewer wrote a composite narrative report summarizing individual interviews and following a format suggested for composite reporting. The composite report was utilized so that the resulting data would present a total picture of the impact investigated instead of the isolated, and sometimes opposing, views of single respondents. It was the interviewer's job to reconcile discrepancies of individual interviews.

The composite reports were also utilized in the other (statistical) approach to treating the data. Appendix M describes how this was accomplished.

Independent variables utilized during the analysis of the Phase II data include the following:

1. Parent participation level
2. Type of delegate agency
3. Area of change (educational or health)
4. Degree of Head Start involvement during the seven stages of the change process.

It will be noted that only two of the four original independent variables appear. Two variables, city size and ethnicity of Head Start clientele, have been omitted. In discussions of the Phase II data analysis with Head Start personnel, it was agreed to place major emphasis on the independent variables of parent participation level and type of delegate agency, since these factors could, in contrast to city size and ethnicity, be altered most easily by Head Start and would thus be more useful in applying research findings to future programs.

Because of the low number of cases studied during Phase II, it was found desirable to reduce to two the number of categorized parent participation levels as high, medium and low, during Phase II the low category was expanded to include medium. With respect to delegate agency, the four original categories (public school, traditional, new, and mixed) were reduced to public school and new (e.g., CAA), and the others were not included in the analysis because there were such a few cases.

Degree of Head Start involvement in the change process was reduced to two categories by including in the high category cases when Head Start was involved in four or more of the possible seven stages of change and including in the low category the other cases.

Most Phase II content code items for which sufficient responses had been secured were cross-tabulated against the four variables discussed. For each of these items, frequencies and percentages (for each independent variable category) were performed. T tests were performed or confidence intervals were established to determine statistical significance at the 95 percent level. Statistical significance at this level was used as the criterion for acceptance of a finding.

COMPARISON COMMUNITIES

Purpose of Comparison Community Research

To provide for some possibility of contrasting results of the communities having Head Start programs to those without Head Start, the "comparison communities" proposal was advanced. These communities would not have to be similar in all but one variable (Head Start) as would controls, but the following criteria were observed in selecting such communities:

1. Absence of a Head Start program or the limited operation of one prior to 1966.

2. Absence of other federal programs similar to Head Start, such as programs financed under the Elementary and Secondary Educational Act (ESEA), Title I.

3. The presence of a poverty population.

4. Absence of suburban contiguity with large metropolitan areas having Head Start programs or other nearby small localities in whose Head Start program the target city might participate.

5. Comparability on regional location, ethnicity, and city size.

This type of comparison would allow the examination of the possibility that Head Start concepts had diffused to community health and educational institutions even though these localities never had Head Start programs.

A great deal of work was involved in identifying, reviewing, and selecting the comparison communities. Relevant data were scarce and often proved inaccurate. The following sources were checked when seeking comparison communities: Directory of Full Year Head Start Programs, CAP Pamphlet C/HS-4, 1968; Profiles of 50 Major Cities, Information Center Reprint, OE, December 1968; Project Head Start - Local Project Approval, Fiscal Year 1965, FY 1966, Summer 1966, 1967, 1968; "OEO Computer Printout List of Head Start Grants 1965-66 for both Summer and Full-Year Programs;" telephone calls to directors of Head Start in the counties identified as possible comparison communities; and other sources.

An initial list of cities considered as possible comparison communities was prepared. However, when investigations of these communities were made many were found to be unsuitable because of having active or prior Head Start programs, not having a poverty population, or being contiguous with metropolitan areas having

Head Start centers. Appendix Table N-1 shows the final selection of matched Head Start communities and non-Head Start communities which were used for comparison purposes.

The design for research in the comparison communities was very similar to that used in the Head Start communities comprising the regular sample. That is, a Phase I survey was conducted to determine if relevant change had occurred. Instruments designed for use in Head Start communities were adapted for use in the non-Head Start locations. It was intended that Phase II interviews be conducted in those comparison communities that exhibited change during the Phase I interviews. In these communities the research plan for Phase II was essentially the same as that utilized in the Head Start communities; attempts were made to trace the processes of change in each of the communities. For communities exhibiting no change, the social and psychological climate was related to the absence of change.

Phase I results revealed change in three of the seven comparison communities; these three were selected for inclusion in Phase II. Also included in Phase II was one community revealing no change. Here, our researcher was asked to determine the reasons for the community's static posture. In the remaining three comparison communities in which no change had been reported local resistance to this study had been so manifest that conducting a second phase was not considered worthwhile. Instead, researchers in the three communities were asked to prepare in-depth reports dealing with the endemic reasons for the absence of change based on insights gained during their Phase I research activities.

Survey Instruments and Respondents

Survey instruments utilized in comparison communities were the same as those utilized in the regular Phase I and Phase II effort. These have been described earlier in this chapter.

The selection of respondents was also the same. However, in many cases local officials in the comparison communities refused to be interviewed and, therefore, low-echelon institutional personnel and individuals representing minority group organizations were substituted.

FIELD RESEARCH PERSONNEL

Research in the sample communities for both phases of this project was conducted by field research associates who are well-qualified and live in or near the communities being studied. It was decided to employ local researchers because, on the basis of past experience in similar projects, it has been noted that they can provide better insights into local events than outsiders.

Field research associates employed during this project were recruited from the faculties of universities and colleges located in or near the sample communities. A number of the field research associates had proven their capabilities during their association with KAI on previous projects. The majority of the field research associates had attained the Ph.D. level in one of the social sciences. Most research associates had extensive research experience and skills in interview techniques.

Field research activities were directed and coordinated by KAI central staff personnel who prepared instructions, revised instruments on the basis of field tests, trained field workers, supervised field work, and checked the work contributed by field research associates.

CHAPTER III

A QUANTITATIVE ASSESSMENT OF INSTITUTIONAL CHANGE

INTRODUCTION

As indicated previously, the research strategy for this project involved a two-phased approach. The purpose of the first phase was to determine if community institutions had changed in ways likely to have been influenced by Head Start. If such institutional changes were found, the second phase was designed to probe whether and how Head Start was involved in the changes. This section of the report deals with the first phase of the strategy, describing and briefly analyzing the relevant institutional changes that were noted. How these changes occurred and Head Start's role in their development are treated in the next chapter.

RELEVANT INSTITUTIONAL CHANGE

First it was decided to attempt to identify changes that appeared relevant to the goals and programs of Head Start and thus likely to have been caused by Head Start. The field work focused on educational and health changes. Among the primary goals of Head Start are educational and health matters, so Head Start would probably have the greatest influence in the educational and health areas. Subsequent efforts to attribute institutional changes to Head Start were expected to be simpler when considering these types of changes. It was also reasoned that if relevant changes in the educational and health areas were not identified, it might be exceedingly difficult to identify other, less proximate types of changes that could readily be associated with Head Start.

Another decision dealt with identifying the types of educational and health changes that seemed most consistent with Head Start's policies and programs. These were changes that, if identified, could be presumed to be related to Head Start. The field work procedures therefore were designed to identify and describe changes of the following general types:

--Increased involvement of the poor with institutions, particularly at decision-making levels and in decision-making capacities.

--Increased institutional employment of local persons in paraprofessional occupations.

--Greater educational emphasis on the particular needs of the poor and of minorities.

--Modification of health institutions and practices to serve the poor better and more sensitively.

Head Start itself involves parents in its programs, employs neighborhood people in paraprofessional roles, is concerned with the special needs of the poor and of minorities, and emphasizes better medical services for Head Start families. Thus, the field work sought to determine if other institutions, particularly educational and health institutions, had changed to reflect these same concerns.

QUANTITATIVE DESCRIPTION OF INSTITUTIONAL CHANGE

The strategy for this aspect of the project was not to attempt to identify the maximum number of relevant changes nor to identify changes in proportion to the number that might have occurred in the communities. As previously indicated, the effort was to determine if such changes had indeed occurred and to learn something useful about them so that a number could be selected for subsequent intensive analysis concerning Head Start's role in the change process. Because this was the strategy, only the most broad types of conclusions, such as those offered below, can be drawn from a quantitative analysis of the findings.

Total Numbers of Changes

Institutional changes consistent with Head Start goals and philosophies were identified in all of the communities investigated.

A total of 1496 changes were identified in the 58 communities studied.[1]

A frequency distribution by community of these institutional changes is presented in Graph 1. The number of institutional changes per community varied from 14 to 40.[2] In over half of the communities surveyed, more than 25 changes were identified. In no cases were there only isolated instances of change. Thus, while it cannot be said at this stage of the analysis that Head Start caused these prevalent institutional changes, it can be seen that changes of a type desired by Head Start have generally occurred in substantial numbers. Reference to the comparison communities (those without Head Start centers) reveals that almost no relevant institutional changes were identified.[3]

Educational or Health Changes

It is important to recognize that the reporting system was established to permit discrimination between changes of an educational and health nature, not between changes in educational and health institutions. For instance, the reassignment of school nurses to provide increased health services in a ghetto school is classified as a health change although it took place in an educational institution.

Included in the educational category were the following types of changes:

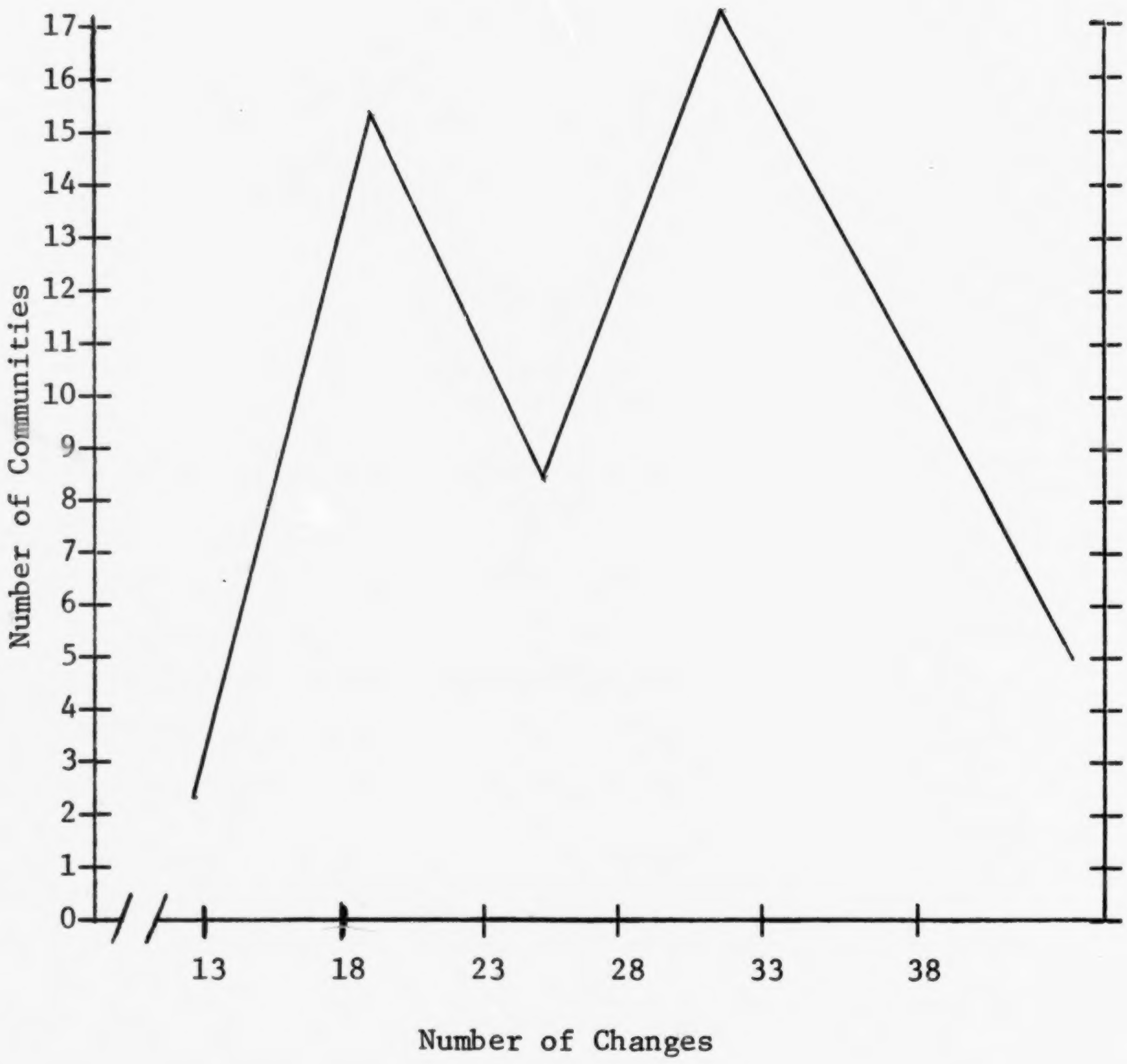
> --Increased employment of school social workers, particularly in ghetto schools.

---

[1] Chapter II described the method of identifying and counting changes. It is almost inevitable that the number of changes indicated here are somewhat fewer than those actually reported.

[2] Because of the data collection system used, no more than 42 changes per community could be reported.

[3] Data from the comparison communities are not included in Graph 1.



GRAPH 1: Frequency Distribution of Number of Institutional Changes (by Community)

--Increased employment of Negro and other minority group teachers and teacher aides.

--Changes in kindergarten and first grade curriculum to reflect needs of low-income children and minorities.

--Increased provision of tutoring and homework assistance in poverty area schools.

--Establishment of kindergartens and prekindergartens.

--Development of special programs for migrant children, slow learners and mentally retarded children.

--Increased conduct of after-hours activity programs in schools in poor neighborhoods.

--Development of parent advisory groups concerned with school issues.

A number of other types of changes reflecting a generally increased community interest in education were also included in this category although they might be less directly related to the needs of the poor.

Included in the health category were the following types of changes. These, because of their public character, tend to serve the poor almost exclusively.

--Establishment of mental health centers in poverty areas.

--Establishment of free dental clinics.

--Establishment of well-baby clinics.

--Decentralization of health-care clinics to serve ghetto areas.

--Development of new planned parenthood clinics.

--Provision of dental and health examinations in schools.

--Increased health services in or from ghetto schools.

The design of the survey and reporting instruments increases the likelihood that more educational than health changes would be reported.[1] Nevertheless, an effort was made to identify the number in each category and to determine their relative distribution by community.

Of the total of 1496 changes identified in the 58 communities, 1055 were educational in nature and 441 were classified in the health category. Graph 2 shows the various proportions of health to educational changes observed in the sample communities, and the number of communities in which each proportion occurs. This graph reflects approximate proportions; the percentages provided thereon represent the midpoints of ranges of ten percentage points.

There are no cases where there are solely health or educational changes in a community. As might be expected, the distribution of changes by community is consistent with the overall finding that about 80 percent of the changes identified are in the educational area.

The data thus indicate not only that community changes consistent with Head Start goals have occurred on a widespread basis but that these changes are prevalent in both educational and health fields, two of the areas of predominant Head Start concern.

Types of Institutional Change

As previously indicated, certain types of institutional changes are considered particularly relevant to Head Start. There is some overlap between this categorization, which follows, and the somewhat broader distinction between educational and health changes which has already been discussed. The 1496 changes identified are found to fall as indicated in the groupings in Table 2.

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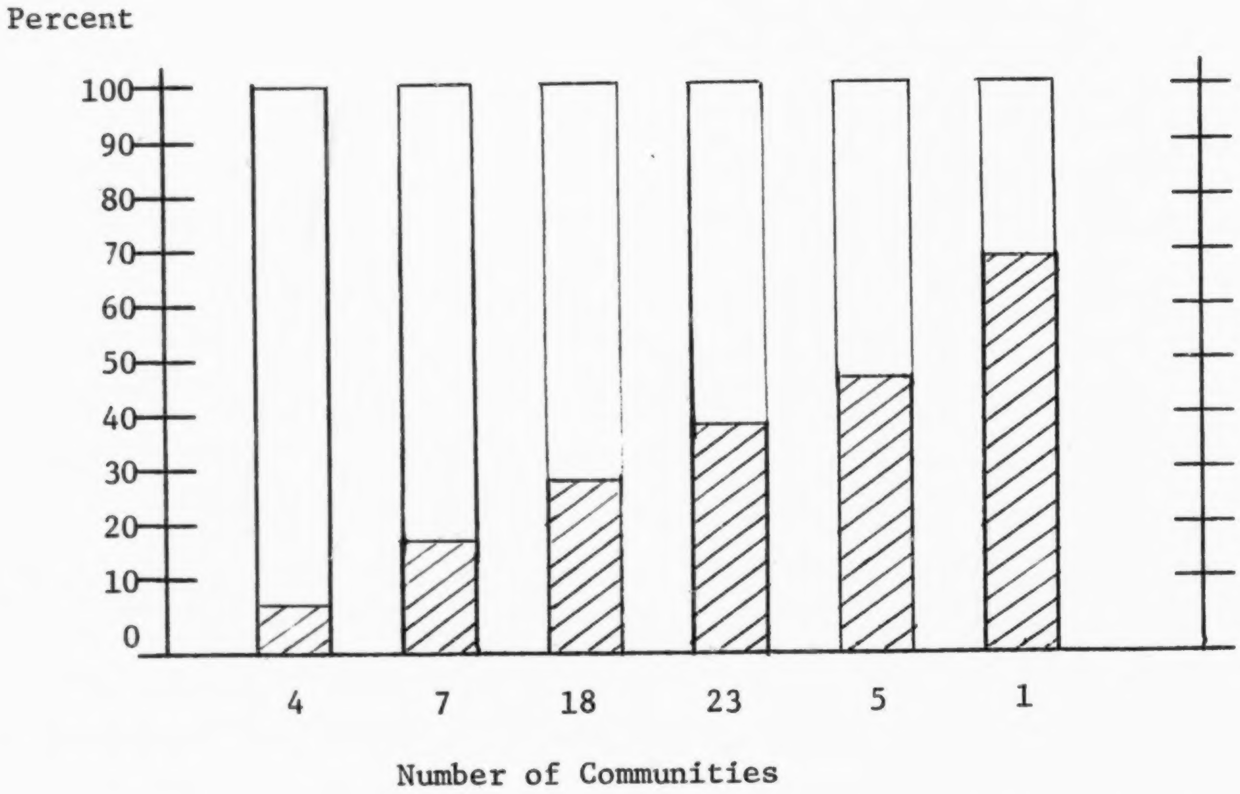
[1] See Appendix F for relevant data collection forms.



GRAPH 2: Approximate Proportions of Health and Educational Changes (by number of communities)

▨ - Health Area

☐ - Educational Area

TABLE 2

Number of Institutional Changes in Each of Four Categories

Category of Institutional Change	Frequency	Percent of Total
Increased involvement of the poor with institutions, particularly at decision-making levels and in decision-making capacities	305	20.3
Greater employment of local persons in paraprofessional occupations	51	3.4
Greater educational emphasis on the particular needs of the poor and of minorities	747	50.0
Modification of health services and practices to serve the poor better and more sensitively	393	26.3
Totals	1496	100.0

In most cases all four types of changes have been identified in a community. Never were fewer than three types of change reported. It is concluded, therefore, that a variety of the important Head Start goals and concepts have been widely adopted. Reference to Appendix I and the examples below indicate the types of changes that occurred in these categories.

> Increased involvement of the poor with institutions, particularly at decision-making levels and in decision-making capacities.
>
> --In a small southwestern village a grass-roots organization has formed a group of Spanish-speaking parents to pressure for changes in school policies and practices. An issue currently in focus is the school system's lunchroom regulation against

students bringing rather than buying lunch. (Many cannot afford the lunches.)

--In the South, low-income people in one community have recently increased their use of public health services and have voiced their opinions regarding improvements needed in the health institution's practices and policies. In response, the health institution has desegregated its waiting room, assigned patients to specific doctors, and opened the facilities one evening a week.

Employment of paraprofessionals in educational institutions.

--A midwestern school system has employed indigenous teacher aides in poverty neighborhoods to tutor children after school.

--A large city school system utilizes paraprofessionals almost entirely in its summer recreation project in the ghettos.

Greater educational emphasis on the particular needs of the poor and minorities.

--Low-cost (and even free) meals are now available to needy youngsters in many communities. Some schools serve a nutritious breakfast, lunch, and an afternoon snack.

--In ____, a school system has placed social workers in ghetto neighborhood schools. Most of these new staff members are black.

Modification of health services and practices to serve the poor more effectively.

--In the South, a mental health facility has been desegregated and actively reaches out to black neighborhoods through churches and anti-poverty programs.

--In Appalachia, a visiting nurse program has been established for the purpose of providing routine nursing care to the sick in an area with a paucity of medical services.

QUALITATIVE DESCRIPTIONS OF CHANGE

The field work program identifying relevant changes did not focus on describing or exploring changes in depth. This was reserved for the next phase of the project when Head Start's involvement in the change process was investigated. Consequently, great anecdotal detail is not available for most of the 1496 changes considered relevant to Head Start's goals. Enough is available, however, to provide a feel for what was found, illustrating the variety of changes noted and included in the tallies in the quantitative section of this chapter.

These qualitative summaries and illustrations are organized in the four categories of change that have been previously used.

Increased Involvement of the Poor with Institutions, Particularly at Decision-Making Levels and in Decision-Making Capacities

In the communities surveyed there has been a notable increase in the participation of parents in the activities of and decisions concerning local institutions. This change seems to have been particularly evident in educational institutions but has also been noted in the health area. One manifestation of change is the increase in the numbers of volunteers helping with school-sponsored activities. Another is the greater use of school facilities after class hours for all types of community meetings, adult education classes, and service programs. In many communities it was noted that the schools have begun to encourage greater involvement by low-income parents, changing policies and regulations to permit this.

> --In _____, for the first time, the school facility in the poor neighborhood is open on Saturday and is widely used by neighborhood groups. The school pays the increased costs involved.
>
> --A large city school system in the Midwest actively seeks visits of parents to ghetto school classrooms and libraries. Signs in the hallways welcoming parents have been posted. (Several years ago, parents were forbidden to enter schools except when contacted first by the school personnel, according to our reports.)

A majority of the school systems surveyed had been influenced by the activities of neighborhood or parent organizations seeking involvement in or control over school affairs. In many communities parent advisory committees have been formed by grass-roots organizations. These may be either permanent-type organizations or groups established for a special purpose.

> --In _____, parents formed an advisory committee which meets regularly with the local school principal and covers almost every possible issue of school policy and practice.
>
> --Parents in ____ demanded that the school superintendent meet with them and he has.
>
> --A militant neighborhood organization of welfare recipients formed an educational advisory group that is proposing to the schools a variety of fundamental long-range educational changes.
>
> --A group of low-income parents organized and participated effectively in a school board election.

Involvement of poor parents has frequently been encouraged by school systems. In some cases the schools have taken the initiative to establish advisory committees involving poor parents. In other cases, the schools have worked with the poor on a single issue. For example,

> --In ____, the school and poverty neighborhood groups worked jointly for the passage of a school bond issue.
>
> --Parents in a large midwestern city have become involved with programs to reduce drug peddling and drug addiction in schools.

In a number of cases, low-income and minority-group members have recently become members of citywide school boards. No instances were reported of complete replacement of established institutions by neighborhood controlled schools as in the Ford Foundation-supported program in Brooklyn. Most changes noted were not so dramatic but represented one or more steps toward parental influence in the schools.

Increased Institutional Employment of Local Persons in Paraprofessional Roles

Paraprofessionals have been employed by school systems under a wide variety of designations to serve a variety of functions. They may be known as teacher aides, clerical aides, home visitors, community relations advisers, assistant social workers or counseling aides. They were generally hired for a variety of purposes as illustrated below:

--In ____, local aides were hired to relieve teachers of certain duties so that the teachers could spend more time working individually with some of the children from poor families.

--Aides in _____ help link the school and the families so each knows the other better and they can work together more closely.

--In ____, aides from minority groups have been hired at least in part to help the school system understand and be more effective with families and children from these groups.

--Case loads had become almost impossible for the social workers associated with the ____ school system. Aides were hired to help catch up, keep up and better service the cases.

--Local people were hired as part-time assistants to help administrators and teachers with clerical work.

It is interesting to note that some school systems offer paraprofessionals a complete career advancement program while others do almost nothing to encourage advancement of aides.

In the health area, paraprofessionals from poverty areas were also employed. The types of employment offered and the reasons for hiring local people were fundamentally the same as in the educational area. One reason was to increase the effectiveness of limited professional resources confronted by increased demand. The other was to serve a new clientele more sensitively and effectively.

Greater Educational Emphasis on the Particular Needs of the Poor and of Minorities

More changes have been identified in this category than in any other. These changes are of enormous variety and scope. For purposes of this report they have been divided arbitrarily into a number of subcategories as indicated below.

Personnel

Changes in the numbers and composition of school staffs have been widely identified. Almost 90 percent of the school systems studied reported that the number of teachers had increased and that more favorable teacher-student ratios had been achieved, particularly in poverty-area schools. Special emphasis has been placed on increasing staff of social workers, counselors, remedial specialists, and nurses who would concentrate their efforts in poor neighborhoods.

Changes in the ethnic composition of professional staffs were reported frequently. More than 70 percent of the school systems reported hiring more Negro and/or Spanish-speaking teachers.

Teaching Methods

The general trend reported was to less-rigid conduct of classrooms, more work with individual children on an informal basis, and encouragement of children to express themselves.

Curricula Content

Examples of curricula changes are almost endless. One very frequently noted area was the addition of content dealing with minority groups. Multi-cultural materials have been widely adopted for early grades, and in the later grades considerably increased attention has been devoted to the contributions of minority group members.

Another curriculum area where much has been reported is increased sensitivity and response to the problems of children who do not speak English or who speak a ghetto dialect.

Physical Facilities

New and improved schools and facilities are widely reported along with complaints that they are still inadequate. Many, but by no means all, of the changes have been reported in the poverty neighborhoods.

Socio-Psychological Services

Social and psychological services appear to have been given greater emphasis in poverty neighborhood schools. The increased employment of social workers, home visitors, and counselors on the staffs of poverty area schools is one indication of the change. In a number of communities it was reported that the "official" emphasis was now on the "total child," not merely his educational attainment (in keeping with Head Start philosophy). Thus, services were being provided that concerned family relations, psychological factors and health.

Enrichment Activities

Included in this frequently noted change are principally field trips to local points and events of interest. Such activities now appear fairly pervasive among schools in the sample communities. One school system is promoting summer "Camperships," scholarships for ghetto children to attend camp. Several have developed new summer programs at school facilities in poor neighborhoods.

New Programs

School systems appear to be placing increased emphasis on the education, health, and development of the preschool child.

A number have established kindergartens and prekindergartens in poor areas; others have developed educational and day-care facilities for the children of low-income working mothers and unwed student mothers.

Some school systems have started adult basic and vocational education and have established comprehensive programs known variously as model schools or community schools. These projects, located in low-income neighborhoods, focus on the educational, social, emotional, and employment needs of all family members. Except for the fact that they highly involve local low-income people in the policy and program decision-making processes, they are somewhat reminiscent of the response of schools and settlement houses to the great waves of immigrants coming to this country around the turn of the century.

Modification of Health Institutions and Practices to Serve the Poor Better and More Sensitively

Health services for low-income families, both public and private, are reported to have changed both qualitatively and quantitatively during the past few years. They have increased qualitatively, according to our reports, in that long-existing services have been improved, more professional people have been hired, hours have been changed, attempts are made to give more personalized service, and facilities have been made more accessible to low-income patients.

> --Public medical facilities have been decentralized by placing substations in the ghetto neighborhoods of ____. Substation services include maternity checkups, immunizations, planned parenthood clinics, and diabetes tests.
>
> --Poor residents in a rural southern area can now avail themselves of the services of a mobile dental clinic. The traveling clinic serves residents of a number of small communities in an area where private dental care is scarce for those who can afford it and nonexistent for those who cannot.

Health services have increased quantitatively according to our survey respondents. The most frequently cited change was in the mental health area, with more than 70 percent of the survey communities reporting positive changes. In many localities comprehensive new out-patient mental health clinics provide services free of charge or have fees based on ability to pay. Other localities have witnessed improvements in their existing public mental health clinics, such as increased staff, additional services, and space for private consultations. Some communities have newly established public clinics designed to rehabilitate people with specific problems such as alcoholism and drug addiction. And there are public clinics staffed by specialists in caring for particular emotional and learning problems of children: dyslexia clinics, speech and hearing clinics, and clinics for emotionally disturbed youngsters.

In addition to the changes in the mental health area, there have been reported other health-related changes. Some examples are:

--Employment of low-income people as paraprofessionals in public and private health services.

--Establishment of health clinics, planned parenthood clinics, dental clinics, prenatal clinics, and well-baby clinics in or near low-income neighborhoods.

--Addition of social workers and home visiting nurses to the staffs of health-care facilities.

--Desegregation of health care facilities.

SUMMARY

This phase of the project sought to answer the question:

Were there institutional changes in the sample communities relevant to Head Start goals?

The answer to this question is "Yes" and, moreover, the work conducted in the field indicates the following:

1. In all communities in the survey there were institutional changes relevant to Head Start goals.

2. In most communities, there were many (approximately 25) relevant institutional changes noted. No communities in the sample (with Head Start centers) showed only isolated institutional change.

3. Both educational and health changes were frequently identified and were widely dispersed throughout the communities.

4. Changes in each of the major categories (increased parental involvement in institutions, increased employment of the poor as paraprofessionals, greater educational emphasis on the needs of the poor, and modification of health institutions to serve the poor) were frequently reported and widely distributed throughout the sample.

The next chapter of this report describes the results of the work done to determine if and how Head Start was involved in a sample of these changes.

CHAPTER IV

WAS HEAD START INVOLVED IN THE PROCESS OF INSTITUTIONAL CHANGE?

PURPOSE

The initial phase of the research, described in the previous chapter, showed the prevalence of institutional changes consistent with Head Start goals and philosophy. What was not discussed, however, was whether these changes were linked to the existence of Head Start centers in particular communities. The purpose of this section is to describe the investigation that was undertaken to determine if Head Start was associated with institutional changes and to present the results of this survey. The focal question addressed is:

> Was Head Start involved with relevant changes in community institutions?

METHODOLOGY

The strategy employed in this phase of the study was to select a variety of institutional changes identified in the first phase interviews and to investigate these changes intensively to determine if and how Head Start was involved.[1] A total of 47 institutional changes in 42 communities was selected for investigation. Due to resource limitations, only one change was investigated in most of the communities; in a few, two were studied. The institutional change areas selected are of considerable variety and are summarized in Appendix J.

The changes were investigated by our field research associates who sought, by means of interviews with knowledgeable respondents, to describe them in detail and to understand how and why they had occurred. Particular attention focused on determining what role Head Start had played in bringing about the particular changes studied.

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[1] See Appendix J for a description of the way this sample was selected.

In order to provide a basis for comparing localities that have felt the direct impact of Head Start with those that have not, seven comparison communities (without current Head Start programs) were chosen and paired with an equal number of full-year Head Start communities taken from the Phase I sample of 58. Each pair was in the same size category, was located in the same geographic region, and had similar ethnic groups in its poverty populations.

At the outset of the study, it was hoped that a great many more comparison communities would be available, but an intensive search revealed only seven that satisfied the criteria for inclusion.[1]

WAS HEAD START INVOLVED IN THE PROCESS OF INSTITUTIONAL CHANGE?

Findings in Communities with Head Start Programs

The investigations revealed that Head Start was involved in 94 percent (44 out of 47) of the changes studied. Head Start was involved in all the 32 changes in the educational area and in 12 of the 15 health-related changes studied.

Head Start was involved in a variety of ways with these 44 changes. In some cases the involvement was crucial and in other cases, relatively minor. The illustrations following indicate the range of the ways Head Start was involved.

We cannot say that Head Start actually caused the changes with which it was involved. The complexities of the environment and the limitations of social science methodology do not permit such statements. However, at this juncture we can relate two important findings, each previously presented separately: (1) Institutional changes consistent with Head Start goals have been widely identified, and (2) Head Start has been associated with most of those changes studied intensively.

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[1] See Chapter II for the process of selecting comparison communities.

Illustrations of Head Start Involvement in Change

Subsequent sections of this report describe systematically in which phases of the institutional change process Head Start was involved, and how Head Start was involved. Before that, however, an indication of the range of specific ways Head Start was involved in the institutional changes studied is presented by reference to a number of individual cases.

In a number of communities, Head Start has provided a way for low-income parents to meet, discuss mutual problems and concerns, and solve them through concerted action.

> --A Head Start center in a northern industrial city was responsible for developing an after-school recreational activity program in some of the ghetto-area schools. This program was later assumed by some of the area schools which began to provide equipment and teachers to supervise the activities.
>
> Head Start staff and parents organized this program originally because of their realization that school-aged Head Start siblings needed but had no place to play after school hours. (Homes are overcrowded and have no yards; this leaves the busy streets, alleys, and sidewalks to be used as playgrounds.) Initially the program for Head Start siblings was held in the Head Start centers with parents alternating as volunteer supervisors. The program became very popular in the poor neighborhoods, non-Head Start families became interested, and Head Start staff requested that the school system take over the program so that it could be enlarged.
>
> --An innovative preventive-health-care project was initiated by a Head Start Policy Advisory Committee in a northeastern industrial city. The committee formed a consumer cooperative which purchases fresh fruits and vegetables in bulk, packages the goods, and distributes

them to families in the ghetto. Much of the work involved in establishing this project was done by the Head Start parents themselves. All of the work involved in purchasing the goods, taking orders from families, and packaging and distributing the food is done by Head Start parents. Assistance in working out some of the technical details was provided by local university faculty members, but most of the credit for establishing this highly successful project belongs to the Head Start parents.

--In a western community, the large Spanish-American segment of the population had felt discrimination by the school system for many years. Furthermore, the Spanish-Americans felt that the school system's refusal to recognize and cooperate with Head Start was an example of its long-evidenced disinterest in educating Spanish-Americans. Head Start parents and staff became incensed, as did a number of other predominantly Spanish-American organizations, and they decided that they should infiltrate and make changes from within. Two events occurred about this time which provided an opportunity for the Spanish-Americans to have a voice in school affairs--the imminent retirement of the conservative school superintendent and a school board election.

The Head Start parents allied themselves with other active minority-group organizations and together they campaigned for a slate of school board candidates who were sensitive to their problems. Their efforts were successful, and they were able to elect a majority of the school board. The next move of the Spanish-American-Head Start coalition was to draw up a list of criteria that it felt should be met by the new superintendent to be selected. This list was presented to the school board in the form of a petition.

The Spanish-American segment of the community feels that the school board was responsive to its suggestions and that the newly hired superintendent meets many of its criteria. Although the superintendent had been in office too short a time to implement many new programs to meet the needs of the Spanish-speaking poor children, their parents feel that his promises to do so are a step in the right direction--and that verbal promises are better than no consideration at all.

> --A large metropolitan community in the West has a quasi-official health-service advisory group as an adjunct to the city government. The group's purposes include identifying community health needs and seeking ways to meet them. Health needs of the poor receive most of the group's attention; the poor and minorities are represented on the committee by members of their own groups. Since its inception, the group has been responsible for a multitude of new public health services and facilities in the city.
>
> Head Start parents and staff have been active in helping carry out the work of the committee and bringing about needed change. For example, in 1965, Head Start parents conducted a survey of health conditions in low-income neighborhoods on behalf of the health-services advisory group, which applied for and obtained federal funds for a massive neighborhood clinic project.

Head Start has introduced new concepts, methods, and curricula into some communities which have been adopted by local school systems or has stimulated schools to make changes to enhance the learning ability of poor children.

> --A New England community school system established a program to employ low-income people as teacher aides. School system representatives indicated that the concept for such a program was introduced locally by Head Start and that Head Start's success in using paraprofessionals in working with poor children had led the school system to adopt its teacher aide program.
>
> Head Start continues to be involved in the school system's teacher aide program by providing pre-service and in-service training for aides in the public schools.

> --A Head Start program in the South has demonstrated that if special effort is made, minority group children from very poor families can learn as well as their middle-class counterparts in school classrooms. The public school system has responded to this demonstration by establishing what are called "adjustment classes." The classes are essentially early childhood education programs for children who cannot adjust to first grade. The classes offer a curriculum that includes reading readiness, vocabulary building, and socialization. The school system's purpose in offering this program is to

> overcome deficiencies in early learning experiences of some children so that they can later adjust to the kinds of experiences they will encounter in regular school classrooms.
>
> --A small community school system in the Midwest now offers remedial help for low-income elementary students through individual and group tutoring programs. A tutoring program was established by a VISTA worker assigned to the area, and a school system staff member was credited with originating the remedial reading program. Although Head Start was not reported to have been directly responsible for stimulating these new programs, local respondents indicated that it had focused attention on the educational needs of poor children and demonstrated that there do exist some effective ways of meeting these needs.

Public school systems and health agencies have frequently developed a greater understanding of and sympathy for the problems of poor families after working with Head Start. As a result, some health agencies and school systems have become more aware of the needs of the poor and have established new programs and services to meet these needs.

> --A Head Start staff in a large midwestern city was reported to have been responsible for encouraging a university medical school to establish a clinic for children with birth defects. The pervasiveness of the need for this clinic became apparent first to Head Start and medical school professional staff members; as a result of their work in poverty areas they noted the high incidence of birth defects due to failure of mothers to obtain prenatal care. This city also has a new prenatal clinic and many other new programs operated by the public health department. There was no evidence, however, that Head Start was directly involved in the establishment of these programs but Head Start does cooperate with and refer its families to them.
>
> --A community school system in the West has developed a program whereby kindergarten children are grouped according to developmental level. Placement of a child into a particular group is determined by his results on a test given to all children prior to their enrollment

> in kindergarten. Head Start staff members feel that this reflects a new concern by public school kindergarten teachers for poor children, many of whom need a special curriculum. The program now in effect provides continuity of instruction from Head Start (at the prekindergarten level) to public school kindergarten.
>
> The concept for this new effort seemed to have grown out of the frequent professional contact that exists between Head Start and public school kindergarten staffs.
>
> --The mental health clinic in one large city has developed a special division for emotionally disturbed children. It was reported by officials of this agency that the need for this service had long been recognized generally, but that it was not until Head Start staff began to refer children to them that they realized how extensive the need was locally. The apparent need and demand for treatment of severe emotional disturbances of these children stimulated mental health officials to apply for federal funds to hire specialists in children's problems and add the children's division to the clinic.

Thus, Head Start has played important, active, and visible roles in the process of local institutional change. Moreover, it is strikingly evident that changes of the type described above were rarely identified in the communities without Head Start that were studied. The work leading to this conclusion is presented below.

FINDINGS OF THE COMPARISON COMMUNITY STUDIES

Introduction

A study of impacts in a limited sample of communities without Head Start programs revealed that, for a number of reasons, little effective work was being done in any of them to bring about meaningful change in the lives of their poor residents.

In contrast, research in an equal number of similar communities, all with Head Start centers, showed evidence of activities to better the conditions of low-income populations. To what extent these activities reflect general community attitudes and to what degree they are attributable to Head Start are unknown. Indeed, the presence or absence of Head Start in itself may be indicative of attitudes toward the poor. However, where Head Start was present, the evidence suggested that it had had a definite positive influence.

Impressions Gained from Comparison Communities When Paired with Head Start Communities

A number of factors were found to be at work in the comparison communities that made change of local institutions difficult or impossible. These factors include:

Attitudes Toward the Poverty Population

The prevailing attitudes in comparison communities were that the poor could be ignored or that they deserved no special consideration. In the Head Start communities, on the other hand, the problems of the poor were visible to public school and health officials who were in a position to help bring about change. For example:

> --In one small northern comparison community, the general feeling was that the local poor were no different from the more affluent--"just lazier." Private physicians there alleged that the poor seemed able to afford everything except good medical care for their children, and that if these parents budgeted their money more efficiently, they could afford the health care their children needed. Spokesmen from other institutions--schools and social welfare agencies--said that poor people, because of their developmental, intellectual, and emotional limitations, were not equipped to take advantage of the traditional educational and health services in the community.
>
> In this conservative town, where thrift and individual effort were held in high regard, the general opinion reported was that each family should pay for what it received, including medical care. No public health programs existed; nor was there a public health nurse, an immunization program, or a maternity or well-baby clinic.

In a counterpart Head Start community, although similar attitudes toward the poor were discovered, significant steps seemed to have been taken toward meaningful change before Head Start became a factor. Before the advent of the local Head Start program, public immunization and nursing services had been available. Head Start's greatest impact seemed to have been in encouraging the low-income families to use existing health services and in coordinating the services offered by different health agencies.

More dramatic contrasts emerged in a study of three small comparison communities with predominantly black poverty populations.

> --In one of these communities, a handful of dedicated persons was found to be working on educational and health problems, but with only partial success at best. One program, supported by a local Negro church, was designed for black preschool children. It was financed almost entirely by parents of the children who paid $1.50 per week for supplies and packed lunches for the children to take to the "school," located in the church building. The program was run entirely by the volunteer efforts of its two founders, an elderly retired black school teacher and a young black minister. It was apparently the only community involvement effort of the poor in this town, and the only educational program available to black preschool youngsters.
>
> --In another isolated effort in the same town, a local public health nurse had been trying to launch a nutritional education program, which was to be available to everyone in the community, but which was aimed primarily at poor families using food stamps. At the time of the study, attendance at her clinic had been light and the nurse felt that many who needed the instruction were not being reached. The poor, she alleged, had shown little interest. She called them "apathetic." She was trying to involve other people and organizations in the program--the Jaycees, the white church women's groups, and other social agencies--but apparently had not tried to elicit the participation of the poor and the black community.

The health, nutritional, and educational needs of the poor seemed to be apparent to only a few individuals in this and other small southern towns that had no Head Start programs.

A markedly different picture had emerged in the two small Head Start communities that were considered along with these comparison communities. In both Head Start communities, significant changes had occurred in recent years, some of them very likely as spin-offs from local Head Start programs.

> --In one of these Head Start communities, important new health projects were developed by a coalition of public and private health organizations after Head Start allegedly considered developing new programs with the help of professional medical personnel from outside the community.
>
> --In the other Head Start locality, the school system obtained federal funds to run new health programs.

Both localities have developed a full range of health services. Respondents agreed that Head Start's role had been to help illuminate the health problems of the poor. Even where the program took no direct action to press for change, it made the needs of the poor visible to local people who had the power to make changes.

Use of Federal and State Financial Aid

A second important factor in the lack of change in the comparison communities was an apparent disinterest in obtaining federal and state funds to finance new programs. Perhaps more significant was a failure in some communities to use available funds in ways beneficial to the poor. Only four of the seven comparison communities were found to be using any federal or state funds; of these, only two had placed the money where the poor felt it was most needed. In the other two, respondents said the funds were channeled into projects irrelevant to the needs of poor people. Thus, the availability of funds does not necessarily result in positive changes for the poor in the areas of education and health. The presence of other forces in the community is required to stimulate health and educational institutions to use funds to make needed changes.

The issue of how available money was used was highlighted in studies conducted in two very small western communities, both of which faced the issue of the employment and utilization of teacher aides in the public schools. The comparison community was one in which school administrators took pride in recent educational innovations.

> --In 1969 teachers' groups demanded that the local system hire teacher aides to relieve teachers of some of the drudgery of their work. The administration and school board were quite willing to go along. State funds were available to finance the aide program and it began during the school year following the negotiations.
>
> At first widespread satisfaction was expressed over the new aides. Groups within the school system saw the program as a solution for pressing problems; the low-income community regarded it as a measure that would provide jobs for its people. After a while, however, the program, which had seemed to hold so much promise, was modified. Job descriptions were rewritten so that only aides with a level of education well beyond that of most poor persons could be hired. The more stringent qualifications for aide positions could be met only by well-educated, highly motivated, middle-class persons who served as assistant teachers. The poor, few of whom could meet these new qualifications, were, in nearly every case, effectively barred from getting jobs as aides.

A teacher aide program in a counterpart Head Start community developed along strikingly different lines.

> --The idea of having aides was proposed by teachers in a poverty-area school who had observed their use in a local Head Start program. The aides were to help in two ways: to relieve teachers of some of their heavy work loads and to give more individual attention to children with learning problems, most of whom were low-income children. Individuals selected as aides came from the neighborhoods where the schools were located. Thus, in this community, aides in the low-income-area schools were low-income people.

> School administrators reported that the aides were responsible for a number of direct and indirect positive impacts on low-income children and their parents. A noticeable improvement in the children's motivation and incentive to learn was reported and attributed to the increased individual attention in the classroom. Also, the aides appeared to have been more successful than regular teachers in communicating with low-income parents. This new link between parents and schools was felt to have enhanced parental interest in the children's academic achievement. Indirectly the teacher aides had been able to interest the parents in reinforcing at home what was being taught at school, and as a result of their success, further changes were being contemplated by school officials. Applications had been made for funds to hire community aides from low-income areas who would visit in the homes of students and further strengthen the link between the classrooms and impoverished homes.

Resistance to Change

A third important factor accounting for the lack of change in the comparison communities was found to be the strength of the local forces resisting change and the absence of any countervailing force that could act on behalf of the poor. In these towns, there were no organizations that had been able to negotiate with or apply pressure on the local establishments with any success. (In five of the comparison communities, signs of community organization of the poor were just beginning to emerge at the time of our research. CAA's and other groups were attempting to provide leadership for the poor, to encourage them to make requests of schools and health agencies, and to organize the poor into political forces within their communities.)

Respondents in the Head Start communities, on the other hand, reported little resistance to change or said that what resistance had existed had been easily overcome. Where negotiation and pressure had been used to achieve change, Head Start staff and parents were frequently involved, respondents said. Again, we do not know whether or not communities now having Head Start programs might not have been equally resistant to change before Head Start arrived. Whatever the case, however, it is fairly clear that Head Start does tend to play a role in overcoming opposition to institutional changes designed to benefit the poor.

Other Motivations for Change

Finally, other factors were at work to promote change in the Head Start communities, but were absent from the comparison sample. For example:

> --A small northern community with a Head Start program was found to have always had generally better public health facilities for its poor than its counterpart comparison community. The former community also has a college which, residents indicated, had played a major role in the development of constructive change. College personnel were initially responsible for writing the proposal and obtaining the funding for the local Head Start program. The comparison community has no college or any other civic-minded group interested in and capable of generating change.
>
> --A northeastern city with a Head Start program depends partially on its reputation as a tourist attraction for its economic well-being. It has not, apparently, wanted to offend tourists with scenes of gross and unrelieved poverty. In addition, the community leaders were interested in maintaining the city's attractiveness, keeping the peace, holding down the crime rate, and avoiding racial disturbances. These considerations led them to implement programs in the local schools, some of them based on Head Start concepts, in attempts to reduce chances of racial violence. A non-Head Start community is comparable to this city in a number of ways and has a sizable low-income black population, although it is economically dependent on industrial rather than tourist activity. Health and educational changes to benefit the poor have not occurred in this comparison community, and representatives of institutions were generally reluctant to admit that there were any poor people living there.

SUMMARY

The investigations of the institutional changes in communities with Head Start programs revealed that Head Start was involved in all 32 of the educational changes and in 12 of the 15 health changes. The comparison communities showed few relevant changes.

On the basis of a limited comparison of communities with and without Head Start programs, it seems evident that Head Start communities tend to be more active in behalf of their low-income populations. Perhaps not all of this change in institutions is attributable to Head Start, but the evidence suggests that Head Start has had some influence. Communities with Head Start centers seem to be more conscious of the needs of the poor and more likely to avail themselves of government funds for programs benefiting low-income persons. In communities that have Head Start programs there also tends to be less resistance to change.

In addition to an antipathy or indifference toward the problems of the poor and the absence of Head Start programs, the comparison communities share other characteristics that appear to have precluded change. Prominent among these characteristics are a paucity of professional and cultural resources and the absence of any visible, successful attempts to organize the poor and minorities into action-oriented groups. Generally, in these localities community leaders have seen little value to the community in making the effort to improve the health or educational opportunities for the poor.

It was frequently noted by researchers in communities with Head Start programs that Head Start has been able to overcome such obstacles as a lack of knowledge and sympathy for the poor, and has provided leadership for the poor at local levels. The information obtained during this study revealed an unquestionable need for change in communities without Head Start programs, as well as a need for individuals and groups (such as Head Start) to serve as instruments in stimulating change.

The next chapter describes an analysis of the various ways in which Head Start was involved with the process of institutional change.

CHAPTER V

THE NATURE OF HEAD START'S INVOLVEMENT IN THE PROCESS OF INSTITUTIONAL CHANGE

PURPOSE

The previous two chapters have indicated, first, that institutional changes consistent with the Head Start philosophy did occur widely and, second, that local Head Start programs were usually associated with these changes. The purpose of this chapter is to describe and analyze the nature of Head Start's involvement in the change process and the role of Head Start as an intervention. This analysis has sought answers to the basic question:

> How was Head Start involved in the process of institutional change?

THE NATURE OF HEAD START INVOLVEMENT

Analytical Framework

For purposes of this project the process of change has been divided into seven stages representing opportunities for an intervention factor to become involved. These stages are defined as follows:

Stage 1: Background Factor. This is the background environment or "climate-for-change" stage. The function performed at this stage is one of stimulating or creating an environment that facilitates change. Though the change idea could occur without such a background climate-for-change, it is much more likely to occur in a conducive environment.

Stage 2: Idea-Proposal. This is the stage at which the idea for change is proposed or initiated. This is a central function of the change process without which the change could not occur.

Stage 3: Support for Change Adoption. During this phase, the function performed is that of support or advocacy for the adoption of the change proposed during the Idea-Proposal stage. Adoption could take place without such support, but may be facilitated by it.

Stage 4: Authorization. This is the stage during which official authorization of the proposed change occurs. Such authorization is a prerequisite to any institutional change, and thus this function is central to the change process.

Stage 5: Resource-Fund Provision. During this stage the functions of funding and providing other needed resources for carrying out the change are fulfilled. This may involve federal grants as well as locally provided resources. Without the necessary funds and resources, institutional change could not occur.

Stage 6: Execution. During this stage, the change is actually enacted or carried out by the appropriate organization and/or persons in behalf of the institution involved.

Stage 7: Support or Cooperation During Change Execution. The function fulfilled during this stage is one of support for the execution of the change or cooperation in the primary enactment function of Stage 6. This is an auxiliary function since change execution may be facilitated by such support but could occur without it (as long as the central execution function itself was fulfilled).

The field data collected were analyzed to determine in each case in which stages of the change process Head Start was involved. The section following is based on these data and analyses. First, however, it should be noted that Head Start has different potentials for being involved during the various stages noted. Some stages, such as Stages 4, 5, and 6 (Authorization, Resource Provision and Execution), are difficult for any organization to accomplish other than the organization actually changing. It is a much easier matter, for example, for Head Start to provide support or advocate that a school hire teacher aides, than for Head Start to authorize their hiring (Stage 4), provide the funds to hire them (Stage 5), or to hire them (Stage 6). One of the interesting and somewhat surprising findings indicated subsequently is that Head Start has participated in all stages of the change process, albeit, as expected, to a lesser extent in the three stages just noted.

The degree to which each Head Start program was involved in each change process was categorized as either high or low, depending on the number of stages in the change process in which Head Start was involved. Head Start programs participating in four or more stages were classed as "high" in their degree of involvement; Head Start programs participating in three stages or fewer were classed as "low." (Head Start's involvement at a given stage was counted only once, regardless of how frequently it was reported.)

Findings

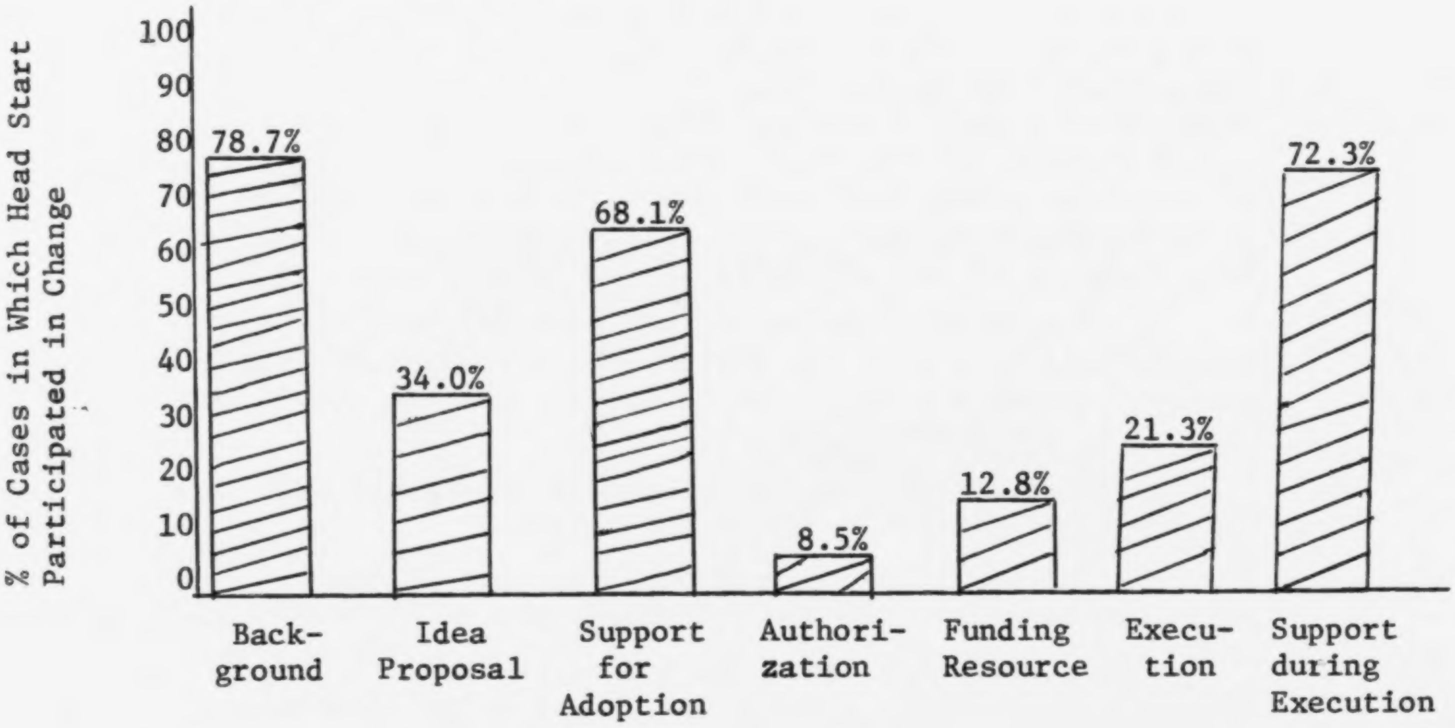
In 94 percent of the institutional changes studied, Head Start was involved in one or more stages of the change process. In a majority of the changes, Head Start was involved at three or more stages as indicated in Table 3. It appears that when Head Start was involved in the change process, its involvement tended to go beyond intervening at only one point in time as when one type of assistance was needed. A continuing involvement seems to be indicated.

For those cases in which Head Start was involved with the change, Graph 3 on the following page depicts the percentage of cases of Head Start participation in each of the stages. If Head Start had been involved in each stage of each change, each bar on the graph would depict 100 percent.

TABLE 3

Frequency of Stages in Which Head Start was Involved in the Change Process

Number of Stages in Which Head Start was Involved	Number of Cases		
	f	%	Cumulative %
None 0	3	6.4	
1	7	14.9	93.6
2	10	21.3	78.7
3	10	21.3	57.4
4	10	21.3	36.1
5	3	6.4	14.8
6	1	2.1	8.4
All 7	3	6.4	6.3
Total	47	100.0	



GRAPH 3: Head Start Participation at Each of Seven Stages of Change Process

It is not surprising that Head Start was less involved in the authorizing, funding and execution stages than in the others for reasons previously indicated (i.e., the low potential for involvement). Indeed, the cases of Head Start involvement in these cases may be of special interest and a number are described subsequently.

As the following examples imply, Head Start has been involved at these three stages by authorizing, providing resources for, or executing only portions of the changes that were made. Only very rarely was Head Start the sole authorizer, resource agent, and executor of all aspects of a change. Head Start has usually been involved at the "Funding-Resources" stage as a provider of non-monetary resources such as volunteer services of parents, technical help by professional staff, or use of Head Start facilities and equipment. In one locality, Head Start authorized a change (Stage 4) and provided funds for it as well (Stage 5).

> --In a small southern community, the Head Start program originally had its own health-care component wherein Head Start funds were used to provide medical examinations and treatment for Head Start children. Health department officials felt that Head Start was duplicating its services and requested that Head Start funds for medical examinations be channeled through the health department. Local Head Start staff was agreeable to the idea because:
>
> 1. The arrangement would relieve Head Start of responsibility outside its educational program activities, and consolidate all local public health work and record keeping in one agency.
>
> 2. A working relationship between Head Start and the health department could be established.
>
> 3. The health department would be able to reach and serve more families through Head Start.
>
> Head Start staff wrote the new procedure into its proposal for the next program year but the OEO Regional Office was prepared to reject it because it was feared that such an arrangement would lead to loss of Head Start's control over the quality of medical care for the children, and would thus seriously jeopardize the

local program. However, after much discussion with local Head Start and health department people, the OEO Regional Office agreed to approve the proposal as written, so that the health department could provide Head Start physical examinations. (There is a general consensus locally that the program is working well, particularly because duplication of services and consequent problems in maintaining health records have been eliminated, and health department services are now reaching more people.)

Head Start also provides resources other than program funds (Stage 5):

--In a large midwestern city, the Head Start program provides training for paraprofessionals employed in various public health services. This community has a large network of health clinics and programs throughout the city, most of them federally funded. When the clinic program received directives from the federal funding agency to expand its program with no increase in funds, the clinics were hard-pressed to maintain their former quality of service. They were faced with the question of how to increase services and facilities without increasing the number of professional staff members.

--Head Start parents in a western city have contributed many volunteer hours to survey the health needs of the city's poverty areas.

--Head Start facilities were being used temporarily as an immunization clinic by a health department with a scarcity of space of its own for large-scale programs.

On occasion, Head Start was found to have implemented a change (Stage 6) before it was taken over by another organization.

--A western community now has a well-baby clinic which was developed originally by Head Start. Realizing the need for such a program, the local Head Start sent its nurse for training in the operation of well-baby clinics and subsequently established such a program for young siblings of Head Start children. (Some years earlier the health department had provided a well-baby clinic but had discontinued it because of lack of funds and personnel.) After establishing

> the Head Start well-baby clinic, the nurse contacted health department officials and asked them to participate by contributing funds and personnel so that the clinic could be opened to all poor preschool children. Initial resistance to the idea was displayed by some of the health officials but this was counteracted by persistent requests from Head Start. The health department now operates a well-baby clinic as part of its total program.

Examples of how Head Start was involved in the other stages of the change process are also interesting to review and a number of typical ones are presented. As indicated in a later section of this chapter, Head Start's role in these stages was often active and intentional. The relatively low frequency of participation in the "Idea-Proposal" stage is somewhat surprising, but the difference between Head Start's participation as a proposer and as a background and support factor is statistically significant.

Head Start was frequently cited as a background factor providing the community climate for change. In a number of cases the local Head Start program was given credit for having introduced new concepts into the community and demonstrating that these concepts were feasible and effective. In many cases, transfer of the concept from Head Start to the "changing" institution (during Stage 1) was direct:

> --An eastern school system began to employ paraprofessionals as teachers' assistants after public school teachers requested them. The teachers who made these requests had taken leaves of absence from the school system and taught in Head Start, where they had gained experience in working with paraprofessionals.

> --A school system in a small southwestern town developed a concern for the health needs of poor children as a result of its being delegated to operate the local Head Start. Poor health and nutritional conditions of the Head Start youngsters were discovered during physical examinations performed on the children. School officials realized at that point that local poor families were not utilizing available health facilities and that few of these people visited doctors except when very seriously ill. Subsequently, the school system applied for and received federal funds to hire a school nurse and four nurse's aides. The objective of the nursing program was to identify health problems of school children, notify parents, and insure that cases were followed up.
>
> This school system also concerned itself with malnutrition of the poor children--another rather universal condition among Head Start children that came to light during their examinations. School officials' awareness of this problem led them to apply for funds to implement hot meal and snack programs in the schools.

In some cases a Head Start concept has traveled to a school system or health institution in an indirect rather than a direct way. The cases below exemplify the unique indirect ways in which Head Start can serve as a background factor for institutional change.

> --In a small community in the South, Head Start's health education programs and referrals to outside agencies were reported to have encouraged the poor to use health facilities when needed. They used the public health services with increasing frequency, and subsequently began to complain about the shortcomings of the services, the inconvenient hours and policies, and so on, within their own groups. As a result, the Head Start parents and staff tried to establish some new programs they felt were needed (family-planning clinics, well-baby clinics, and home-visiting services), but they were unsuccessful because local medical people refused to provide them with the necessary technical and professional assistance. For several years there

> were undercurrents and rumors that Head Start and the local CAA were still trying to obtain the programs they wanted and would, if necessary, "bring people in from the outside" to run them. (There were no evidences of plans of this nature either by Head Start staff or parent groups.) Fear of a program run by outsiders stimulated the private and public health people in the community to act, and together they worked out plans for a number of new programs and services--a mental health clinic, family planning, well-baby clinics, and home-visiting services.
>
> --Head Start created an impact in a conservative community in the Midwest simply by doing its job in educating poor children in the community. All the attention received from the school system by poor children via Head Start and ESEA-financed projects resulted in a backlash outside the poverty areas. Parents in a lower-middle-class section of town resented the relative lack of emphasis on programs for their own children and presented demands to the board of education for some special programs in their own neighborhood grade school. Many of the families in this area were barely above the poverty line and resented the fact that their children were not eligible for Head Start. Apparently the parents had no difficultly obtaining an agreement from the school superintendent for a special program for their children. It seems to be a commonly held notion about the community that the superintendent is eager to become known as an innovator. "It's either innovate or perish if you want to get ahead in the field," he has stated. Respondents in this community feel that this is one reason the parents' demands were met so readily. The superintendent established an experimental curriculum for the school which required very little in the way of additional funding.

In over one-third of the cases, Head Start parents or staff members were responsible for proposing a change (Stage 2). The following summaries indicate the variety of circumstances under which parents and staff proposed ideas that stimulated changes in schools and health agencies.

--One of the best examples of successful attempts to obtain institutional change is provided by a school system in a predominantly black southern community, which now operates a comprehensive health clinic. This school system has altered its traditional role of educator to include that of health-care provider as well. The idea for a health-care facility was generated by a Head Start nurse who realized the need for such a program after examining the Head Start enrollees, most of whom exhibited symptoms of chronic disease and malnutrition. Many had never been examined by a doctor. The nurse presented these facts to public health and school officials and requested their help in finding a solution to the problems. Together they worked out a plan whereby the school system would apply for federal funds to establish and operate a health clinic for children and would draw on other community health resources as needed.

--A health-care clinic in an eastern industrial city represents the culmination of many month's effort by Head Start parents, university medical students and faculty members, and the public health department. The concept for this clinic appears to have been the brainchild of Head Start parents and other members of the Head Start Parent Advisory Committee.

--The processes leading to curricular changes in a southern school system appear to have originated in a black[1] PTA organization whose members found reason to criticize the content and relevance of classroom work. The parents requested a study of the curricula, which was conducted by professionals in the educational field and presented to the school system with recommendations for changes. These changes were subsequently implemented by the school system.

--Head Start parents in a western city allied themselves with local black activist groups to bring about specific changes they wanted in the school system. Head Start staff and delegate agency people organized parents and encouraged them to press for changes such as hiring Negro teachers aides and providing free hot lunches for needy children.

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[1] It was reported that most of the white parents had resigned from this PTA because of the heavy influx of blacks into the organization after the inception of Head Start and desegregation policies.

Head Start staffs have demonstrated support for adoption and execution of changes (Stages 3 and 7) by such activities as assisting in the establishment of new programs and encouraging parents to take advantage of them. For example:

> --A southern health agency recently increased its public nursing staff by four so that its services to poor families could be augmented. Head Start staff was apprised of this change when it was in the planning stages and was asked to let Head Start parents know about the new services and encourage their use.
>
> --Staff of a western Head Start program helped a local school system plan a new curriculum for kindergarten students.
>
> --A midwestern Head Start staff helped solicit donations for a new eye clinic and eye glass bank. Since the clinic's inception, Head Start has referred many children with vision problems.

Summary

The findings indicate that when Head Start was involved in the process of institutional change it tended to be involved in more than one stage of the change process. Expectedly, it was involved in the background, idea-proposal, support for change adoption, and support during change execution stages--the stages where there was the greatest potential for intervention. Also, in a limited number of interesting cases, Head Start was involved in the authorization, funding, and implementation stages of the change process.

THE ROLE OF HEAD START IN THE CHANGE PROCESS

Analytical Framework

Utilizing the same case study material, an effort was made to organize and analyze the data to determine how Head Start had been involved. Particular attention was given to the stages in which Head Start was involved most frequently--background, support for change, and cooperation during change execution.

Background Stage Analysis

Reference to the specific cases studied indicated the ways of fulfilling the background stage and creating an environment conducive to the idea of change. These were as follows:

1. Economic or Legal Factors: presence of or increase in funds, grants, or facilities available for change (e.g., OEO grant for community improvement); presence of legal requirements (e.g., integration in the public school system).

> --Head Start funds were granted to provide for medical examinations for enrollees. A public health clinic agreed to provide the examinations and employed paramedical aides to help with the children.

2. Personnel Factors: presence or increase in personnel capable of carrying out a change or likely to propose it (e.g., arrival of Head Start personnel with previous experience in similar community problems and change programs).

> --In a northeastern city, a Head Start Policy Advisory Committee member had learned about consumer cooperatives in the community in which he had lived previously. This man was one of those who were instrumental in assisting the Head Start parents to organize their own food purchasing cooperative.

3. Organizational Factors: presence of an organization appropriate to carrying out a change or likely to propose it (e.g., creation of a local Head Start with its facilities for instituting and administering community change.)

> --Public and private medical personnel in a small town in the South became alarmed on hearing the rumor that Head Start was going to start a public clinic. Allegedly Head Start was planning to import new doctors "from out of town" to operate the clinic. Although the rumor was never substantiated, the threat of competition was said to have motivated local health personnel to take an interest in the poor and establish many new public health programs.

4. Psychological "Climate" Factors: presence of, increase in awareness of, or interest in a problem or need and support for solving it (e.g., the community's awareness of a problem and desire for change increases--perhaps due to conscious efforts on the part of concerned people or groups such as Head Start to arouse such community interest).

> --Friction between public school and CAA/Head Start personnel drew public attention and Head Start was able to focus public interest on an old issue--that the minority group children were being discriminated against in the schools.

5. Physical Environment, Extraneous Factors: onset of or increase in the problem itself which therefore necessitates a change (e.g., influx of poor people to a community, creating the need for medical or educational programs to serve them); failure of alternative solutions to the problem.

> --Head Start parents learned about health facilities and began to use them with increasing frequency, thus placing a burden on staff and facilities. In order to meet the new demands on its resources, satellite health centers were built in poverty neighborhoods and new personnel were employed to staff them.

6. Example Factors: presence of persons or organizations in a community who direct themselves toward solving a problem and by their own activities lead other organizations or groups in the community to follow their example and try to improve conditions themselves (e.g., Head Start efforts to improve medical care for the poor are noticed by the local public health system which then becomes aware of the need and institutes a similar program of its own to alleviate the problem).

> --Public school personnel serving temporarily with Head Start observed the successful use of teacher aides and recommended that the regular school system also employ aides.

As indicated in Table 4 below, when Head Start contributed to the background for change, it was found to have acted predominantly to focus community attention on a problem and increase the desire for its solution. In 82 percent of all cases, Head Start did this by serving as an example through its own efforts to solve a problem. In 59 percent of the cases, Head Start attempted to create a psychological climate for change by intentionally stimulating community concern.

TABLE 4

Frequency of Various Ways in Which Head Start Participated During Background Stage

Type of Background Factor	Number of Cases	
	f*	%*
Economic, Legal	5	12.8
Personnel	4	10.3
Organizational	10	25.6
Psychological Climate	23	59.0
Physical, Extraneous	3	7.7
Setting an Example	32	82.1
Other	0	0.0
NA	2	5.1

N = 39 (100%)

* Percents exclude those 8 impact cases where Head Start was definitely not mentioned as participating in the background stage and are based on a total N of 39 (not 47) cases where Head Start was either definitely involved as background or where it could not be ascertained (NA) if Head Start was involved. Total f's can equal more than 39, and total percentages more than 100, since more than one background factor can apply in a single case.

A number of illustrations of how Head Start was involved during the background stage are indicated below. In some communities, Head Start provided an example to school systems of ways to use available federal funds.

> --School officials indicated that although the availability of federal or state funds had motivated them to initiate change, the example shown by Head Start provided them with ideas for using the funds effectively. For instance, many school officials and teachers were aware that teacher aides and social workers were being used successfully in Head Start, and they saw the employment of similar people in the school system as the answer to solving some of the schools' difficulties in communicating with poor children and their parents. Special remedial programs and experimental projects were started because school officials were aware of similar activities in Head Start and felt they could be effective.

A number of school systems were motivated by racial militancy or demands from civil rights organizations to make changes, and local Head Start programs served as examples for the kinds of changes that were made.

> --Ghetto rioting during the summers of 1965-68 gave the schools cause to study some of the factors contributing to the social unrest and to reflect on the school system's role in counteracting them. Two school systems appointed committees to study the problems and recommend possible solutions and actions that the schools could take. Both committees were said to have consulted with local Head Start personnel and both recommended changes modeled on Head Start programs. New programs were implemented in both communities with the use of federal funds.

> --Other school systems were motivated by complaints from civil rights groups stating that inequality of opportunity existed in the city schools and that steps should be taken to eliminate *de facto* segregation. One of these communities, a small southern town, agreed to integrate the schools immediately but found that additional personnel would have to be hired to handle students' records, transfer information, etc. The school

system decided to follow Head Start's example and hire teacher aides to do the extra clerical work. Another school system appointed a study committee in response to the allegations of discrimination by civil rights groups. The comprehensive study revealed the inequities in the schools and recommended an overhaul of the entire system. Many of the specific changes recommended by the committee were based on Head Start concepts and practices; for example, use of professional and paraprofessional teachers from minority groups, use of multicultural textbooks and materials, and involvement of parents in policy-making, planning, and activities.

--The persistent efforts of one individual--a Head Start director--were reported to have been solely responsible for bringing about an enlargement of the health department's immunization program. In this western city, DPT immunization had been available for a number of years for children who were taken to the health department for this service. But few parents knew about this service, few realized the importance of it, and consequently few took advantage of it. A large proportion of the children who enrolled in Head Start had never had DPT immunizations and this fact was discovered during the children's Head Start physical examinations. This discovery instigated the Head Start director's campaign for an enlarged immunization program that would serve a greater number of children and include immunizations against smallpox, measles, and polio as well as the DPT series. Bringing about this change was difficult, for the local health officials were extremely reluctant to enlarge the scope of services, but after a year of almost constant pressure from and negotiation with the Head Start director, the health department enlarged its immunization program.

Analysis of Support for Adoption (Stage 4) and Cooperation during Change Execution (Stage 7)

With respect to ways of fulfilling the support for adoption stage and the final stage, cooperation during change execution, a number of alternatives were noted:

1. Direct Action or Influence: formal advocacy of change adoption or direct cooperation and participation in its execution;

offer of services to promote adoption or execution; direct attempts to influence the relevant (to-be-changed) organization to adopt or execute a change or active efforts to call its attention to a problem (e.g., Head Start conducts a survey to point out the health needs of the poor to the public health system, encourages it to institute new clinics, and offers volunteer help in conducting clinical services). To illustrate:

> --Head Start provides a training program for all teacher aides employed throughout the school system, including those in Head Start.

2. Influence on Other Organizations or Official Persons (an indirect method): This method is one of showing support for change indirectly by encouraging other organizations and groups to support or campaign for change adoption or to cooperate in its execution. It is indirect because the actor does not directly participate himself or exert his influence directly on the primary (to-be-changed) institution (as in Method 1), but instead uses his influence to get other organizations in the official community involved (e.g., Head Start encourages minority group organizations to put pressure on the public school system to institute remedial reading courses and encourages them to cooperate and participate in such a program when it is adopted).

> --In a southwestern community, Head Start allied itself with prominent, active Mexican-American organizations to campaign for changes it felt were needed in the school system.

3. Influence on Private Citizens, Parents, Private Groups (an indirect method): This method also involves showing support indirectly, but this time by directing influence toward the private sector (individuals and groups) rather than the official sector. Those who employ this method do not directly participate or try to exert influence on the primary (to-be-changed) institution,

but instead direct themselves toward encouraging private individuals and groups to advocate change adoption or to cooperate or participate in its execution (e.g., Head Start encourages local parent groups to campaign for the provision of school medical exams for children; Head Start encourages local residents to demand new clinic services from the public health system and influences them to take advantage of or participate in the new services when they are adopted).

> --Head Start parents and staff in a northeastern city helped to generate a feeling of acceptance among the poor for staff of a new health clinic being built in the area. Head Start parents and Policy Advisory Committee members held meetings in their homes and invited other area residents to hear discussions of clinic services and to meet the new staff. Leadership provided by Head Start parents and indigenous staff was reported to have been a prime factor in overcoming local resistance to the "outsiders" who were staffing the new clinic.

> --Staff members of a southern Head Start program have encouraged Head Start parents to apply for teacher aide and home-visitor positions in the public school system.

> --Head Start children, siblings, and parents in a mid-western city are frequently referred to the new health-care programs in the community for medical treatment, family planning consultation, dental care, prenatal care, and immunizations.

4. Emotional Reaction: This method does not involve action of any kind and merely represents the "support" afforded by agreement with or enthusiasm for a change. It was coded only if no other method was used to show support.

> --Head Start was in favor of using more teacher aides in a public school system but did nothing to show its support when such a program was introduced.

In fulfilling its functions of supporting change adoption and cooperating during change execution, Head Start involvement was overwhelmingly that of an active participant, as indicated in the tables below. In 88 percent of the cases when Head Start was supporting change adoption (see Table 5) and 82 percent of the cases when it was supporting change execution (see Table 6), Head Start used direct, active methods to show its support. As indicated in Table 6, Head Start frequently took advantage of its grassroots contacts to encourage private individuals and groups to support changes. Other methods of support were used infrequently.

TABLE 5

Frequency of Use of Various Methods by Head Start to Support Change Adoption

Type of Method	Number of Cases	
	f*	%*
Direct Action	29	87.9
Influence on Other Organizations	12	33.0
Influence on Private Persons, Groups	9	27.3
Emotional Reaction	1	3.0
Other	0	0.0
NA	1	3.0

N = 33 (100%)

* Frequencies and percents exclude those 14 impact cases where Head Start was definitely not mentioned as participating in the support for change adoption and are based on a total N of 33 (not 47) cases where Head Start was either definitely involved as supporter of change adoption or where it could not be ascertained (NA) if Head Start was involved. Total f's can equal more than 33, and total percentages more than 100, since more than one method could be used in a single case.

TABLE 6

Frequency of Use of Various Methods by Head Start to Support or Cooperate during Change Execution

Type of Method	Number of Cases	
	f*	%*
Direct Action	28	82.4
Influence on Other Organizations	10	29.4
Influence on Private Persons, Groups	17	50.0
Emotional Reaction	1	2.9
Other	0	0.0

N = 34 (100%)

* Frequencies and percentages exclude those 13 cases where Head Start was not mentioned as participating in support during change execution and are based on a total N of 34 (not 47) cases. Total f's can equal more than 34, and total percentages more than 100, since more than one method could be used in a single case.

Summary

Head Start has generally been actively involved in encouraging the process of institutional change. This was true at both points of Head Start's greatest involvement in the change process--in the background and supportive stages.

OTHER ASPECTS OF HEAD START'S INVOLVEMENT WITH CHANGE

Utilizing the same case study data, an attempt was made to ask and answer a number of closely related questions that might illuminate further Head Start roles and impacts in the process of institutional change. A number of these are discussed below.

Target Population Characteristics

> How did the characteristics of the target populations of changes differ when Head Start was involved to a high as compared to a low degree?

Three types of characteristics were the focus of these analyses: economic level, ethnic composition, and age-role status. It was found that the degree to which Head Start was involved in a change differed depending on the type of people toward whom that change was directed. With respect to the economic level of the target population, Head Start centers in our sample that were highly involved in the overall change process were associated a greater percentage of the time with changes directed toward the "poor only."[1] Table 7 shows that in 71 percent of the cases with high involvement centers, the change was directed toward the poor alone, whereas in only 43 percent of the cases with low involvement centers were poor people the only target. However, this difference was not great enough to achieve statistical significance, and consequently it must be concluded that the economic level of the people toward whom institutional change is directed has no influence on the extent to which a Head Start center becomes involved in the process of change.

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[1] Possible "economic level" categories were "poor only" and "poor and not poor" (i.e., all people, regardless of economic level).

TABLE 7

Relationship of Degree of Head Start Involvement to Economic Status of Target Population of Changes

Economic Status of Target Population	Degree of Head Start Involvement			
	High		Low	
	f	%	f	%
Poor	12	70.6	13	43.3
Poor & Not Poor ("all people")	5	29.4	17	56.7
Total	17	100.0	30	100.0

N = 47

As to their racial-ethnic composition, the predominant target populations of change for both high- and low-involvement centers were mainly whites and/or Negroes, with about 75 percent of all changes being directed toward these groups in contrast to the 20-40 percent of all changes directed toward Spanish-Americans. It is not surprising that fewer changes were directed toward Spanish-Americans since only about 15 percent of the changes studied in Phase II occurred in communities with sizable Spanish-American populations. What is important is that Head Start was frequently highly involved when the proposed beneficiaries of change were Spanish-American people. Table 8 shows that in 41 percent of the changes associated with high-involvement Head Start centers, the target population included Spanish-Americans, while this was true in only 20 percent of the cases with low-involvement centers.

TABLE 8

Relationship of Degree of Head Start Involvement to Racial-Ethnic Status of Target Population of Changes

Racial-Ethnic Status of Target Population	Degree of Head Start Involvement			
	High		Low	
	f*	%*	f*	%*
White	14	82.4	23	76.7
Negro	13	76.5	22	73.3
Spanish-American	7	41.2	6	20.0
Other	2	11.8	0	0.0
NA	0	0.0	2	6.7

N High Involvement = 17 (100%)
N Low Involvement = 30 (100%)

* Percents total more than 100 percent and f's total more than 17 and 30 since a single change could have been directed toward more than one racial-ethnic group as its target population. Percentage figures reflect the proportion of the frequency of each ethnic group at each level of involvement.

Finally, there also appeared to be a relationship between the age-role status of change beneficiaries and the degree of Head Start's involvement in the change. Although children were a predominant target population for changes associated with both high- and low-involvement centers (in 88 percent and 97 percent of their changes, respectively), high-involvement centers were also associated significantly with changes directed toward parents, while low-involvement centers were not. Table 9 shows that 82 percent of the high-involvement centers were associated with changes that included parents as beneficiaries, while this was true in only 47 percent of those cases where Head Start involvement was low.

TABLE 9

Relationship of Degree of Head Start Involvement to
Age-Role Status of Target Population of Changes

Age-Role Status of Target Population	Degree of Head Start Involvement			
	High		Low	
	f*	%*	f*	%*
Children	15	88.2	29	96.7
Parents	14	82.4	14	46.7
Other Adults	9	52.9	11	36.7
Others (e.g., teenagers)	10	58.8	15	50.0

N High Involvement = 17 (100%)
N Low Involvement = 30 (100%)

* Percents total more than 100 and f's total more than 17 and 30 since a single change could have been directed toward more than one age-role group.

To summarize our findings with regard to the target population of change, Head Start centers with high involvement in the overall impact process were associated more often than low-involvement centers with changes directed toward Spanish-Americans and parents.

Opposition to Change

> Was there any more or any less opposition to those changes associated with high-involvement Head Start centers than to changes associated with low-involvement centers?

Resistance and opposition to change came from many sources, including in some instances the poor themselves. Following are some illustrations of activities in opposition to change.

> --A health clinic in the Northeast was advocated by Head Start and a group of medical students. Initially it did not receive support from the medical school officials, medical associations, local hospitals, or the poor. Their resistance was characterized by a refusal to act rather than counteraction, and by a refusal to participate rather than overt activity to hinder establishment of the clinic. Head Start was reported to have been instrumental in overcoming resistance to this change, especially among the poor.
>
> --Resistance to a proposed mental health center in a southern community came from right wing organizations which felt that the new center would be part of a Communist conspiracy. Resistance was not strong enough to be a barrier to establishment of the clinic.
>
> --In a large northern industrial city a proposal to employ vast numbers of paraprofessionals in the health-care programs was widely supported. The proposal's advocates included the antipoverty program staffs, public and private medical people, and the poor themselves. The major resistance to the program came from the city's licensing agencies and the civil service board. With the mayor's intervention and Head Start's promise to train people to assume these jobs the resistance of the city agencies was overcome.
>
> --In a New England community some public school teachers were against the ideas of having nonprofessionl people perform teaching duties. Many others involved (including teachers, aides, principals, and antipoverty program people) felt that many paraprofessionals then possessed inherent, natural talents for working with children and should not be precluded from doing so. After much negotiation between the two "factions," a compromise was reached whereby teacher aides would be able to work with children in the classrooms but would not be allowed to introduce new material.

The data indicate that there are differences in the frequency with which changes associated with high- as compared with low-involvement centers were opposed by other organizations or groups. Table 10 shows that as many as 71 percent of the changes associated with high-involvement centers encountered opposition from other groups or organizations, while only 40 percent of the changes associated with low-involvement centers were opposed. Perhaps the presence of opposition (providing a threat to the successful initiation and execution of change) required that Head Start become involved during several stages of the change process in order to overcome this obstacle and ensure the successful enactment of the change. Unopposed changes might not have demanded such intensive efforts by Head Start to ensure their achievement, and thus might have been associated more often with low-involvement Head Start centers.

TABLE 10

Relationship of Degree of Head Start Involvement to Presence of Opposition to Change

Presence of Opposition	Degree of Head Start Involvement			
	High		Low	
	f	%	f	%
Yes	12	70.6	12	40.0
No	5	29.4	17	56.7
NA	0	0.0	1	3.3
Total	17	100.0	30	100.0

N = 47

Modification of Change

Was there any relationship between the level of Head Start's involvement in an institutional change and modification (expansion or decrease) of the change after its inception?

Many of the institutional changes studied had undergone modification since their inception. Some changes had proven to be effective, successful, and popular and were thus increased in scope so as to provide greater benefit. Others had been less successful or funds had been cut, and as a result the programs had been decreased or eliminated. The examples below illustrate, first, an institutional change that was expanded in scope and, second, a change that was decreased.

> --During the first year after its inception the teacher aide program in _____ employed 10 people serving in three elementary schools. Prior to the second year requests from schools and principals for teacher aides increased greatly, and the school system applied for an increase in funds for the second program year. Additional funds were granted, and during the second year the size of this program was nearly quadrupled.
>
> --In _____, the teacher aide program in the secondary schools was eliminated entirely so that additional funds could be made available for a new remedial reading program.

It was found that the changes associated with high-involvement centers were enlarged or expanded upon somewhat more often that those associated with low-involvement centers (71 percent as compared with 57 percent). However, this difference was not statistically significant (see Table 11).

TABLE 11

Relationship of Degree of Head Start Involvement to Modifications (Expansions - Decreases) in Changes

Type of Modification	Degree of Head Start Involvement			
	High		Low	
	f	%	f	%
Expansion	12	70.6	17	56.7
Same (no modification)	4	23.5	9	30.0
Decrease	0	0.0	1	3.3
NA	1	5.9	3	10.0
Total	17	100.0	30	100.0

Involvement of CAA and Private Sector

> Was the participation in change of the CAA's and of private groups and individuals similar to or different from that of Head Start?

Up to this point only the involvement of Head Start in the change process has been dealt with. However, other organizations, groups, and persons also participated during the various stages of change processes, and two of these--Community Action Associations (CAA) and the "private sector" of the community--were seen as particularly relevant to an understanding of Head Start involvement in community change.

CAA involvement in community change was seen as important because of its close national and local ties with Head Start and its broader efforts on behalf of the poor. An analysis of CAA participation at each of the stages in the change process was therefore made to determine if CAA's and Head Start organizations performed parallel functions through their involvement in change (with CAA participating more frequently during those stages and in those changes where Head Start also was highly involved) or if their functions counterbalanced one another (with CAA participation being greater when Head Start was not highly involved). As shown in Table 12 it was found that substantial CAA participation in the change process occurred only for four functions: background, support for change adoption, cooperation during change execution and idea-proposal. Thus, the CAA's and Head Start were involved at the same stages of change. Those functions performed only minimally by Head Start were not fulfilled by CAA's. Many of the functions that CAA did perform were performed a significantly greater percentage of the time in those changes in which Head Start was also highly involved. Table 13 shows the relationships between Head Start and CAA involvement at each stage of the change process. Significant differences were found in its "background" function, where CAA participated in 65 percent of the changes associated with high-involvement Head Start centers as compared with only 37 percent of those associated with low-involvement centers; in "resource-fund provision;" in "support during change execution;" and in the "idea-proposal" function. It appears that CAA's functioned in a manner similar to or parallel with that of Head Start in its involvement in the change process. Both performed the same functions within the change process and fulfilled them much more frequently in those changes where Head Start was also highly involved. Perhaps deep involvement and concern for community change on the part of one

TABLE 12

Frequency of CAA Participation According to
Stage of Change Process

Stage of Change Process	f	%
Background	22	46.8
Idea-Proposal	12	25.5
Support for Change Adoption	23	48.9
Authorization	3	6.4
Resource-Fund Provision	8	17.0
Execution	5	10.6
Support, Cooperation During Change Execution	19	40.4

N = 47

organization influenced the other to become highly committed as well. It is also possible that the characteristics of the change itself and the degree to which it served the similar Head Start and CAA purposes and interests led to their parallel involvement patterns.

TABLE 13

Relationship of Degree of Head Start Involvement to CAA Participation in Change Process

Stage of Change Process	Frequency of Changes Participated in by CAA			
	Changes Associated with High-Involvement HS Centers		Changes Associated with Low-Involvement HS Centers	
	f	%	f	%
Background	11	64.7	11	36.7
Idea-Proposal	10	58.8	2	6.7
Support for Change Adoption	11	64.7	12	40.0
Authorization	2	11.8	1	3.3
Resource-Fund Provision	5	29.4	3	10.0
Execution	2	11.8	3	10.0
Support, Cooperation During Change Execution	11	64.7	8	26.7

N High Involvement = 17 (100%)
N Low Involvement = 30 (100%)

In addition to the CAA, the pattern of participation in the change process of a second group outside Head Start was also seen as relevant to an analysis of Head Start involvement in community change. This second group was the "private sector" (private individuals and groups), consisting predominantly of the local area residents and the poor themselves who were the presumed beneficiaries of the change. Following the Head Start goal of improving conditions for the poor, it would be expected that where the local, private citizens were themselves committed highly to a change and participated actively in the change process, Head Start would also have become more deeply involved in order to protect their interests and ensure for them the benefits provided by the change. Moreover, following another Head Start aim--that of involving the local residents in attempts to improve their own living conditions--it would be likely that, where Head Start was highly involved in a change, it would have encouraged private, local citizens to participate actively and become more highly involved themselves. Since both of these views would predict a parallel involvement in the change process by Head Start and the private sector, the presence of such parallel participation in change would indicate that these important Head Start goals were being followed.

Accordingly, an analysis was made of the degree of involvement of the private sector in changes associated with high- and low-involvement Head Start centers in order to determine if such parallel functioning occurred during the various stages of the change process. Table 14 shows that for changes associated with both high- and low-involvement Head Start centers, the private sector served predominantly in a supportive capacity, performing the functions of background, support for change adoption, and cooperation during change execution. This was to be expected, since the nonofficial status of such private individuals and groups would necessarily have limited

TABLE 14

Frequency of Participation by Private Sector
According to Stage of Change Process

Stage of Change Process	f	%
Background	11	23.4
Idea-Proposal	3	6.4
Support for Change Adoption	11	23.4
Authorization	3	6.4
Resource-Fund Provision	4	8.5
Execution	5	10.6
Support, Cooperation During Change Execution	16	34.0

N = 47

them to supportive activities. In most cases, private citizens do not possess the organizational, personnel and financial resources necessary to function in other than supportive roles during the change process. In fulfilling their functions, however, it was found that private individuals and groups did participate in many more changes associated with high-involvement Head Start centers than in those where Head Start involvement was low. In its background function, the private sector participated in 35 percent of the changes associated with high-involvement Head Start centers as compared with only 17 percent of those where Head Start involvement was low; in supporting change adoption, these percentages were 41 percent and 13 percent, respectively; and in cooperating during change execution, the percents were 53 percent and 23 percent. (See Table 15.) Thus, it seems that, as predicted, Head Start and the private sector functioned in a parallel manner in the change process, with the private sector participating more highly in changes where Head Start centers were also highly involved. This similar involvement pattern could indicate that mutual cooperation in working toward community change existed between Head Start and the local area residents--an important objective of the Head Start philosophy.

TABLE 15

Relationship of Degree of Head Start Involvement to Participation of Private Sector in Change Process

Stage of Change Process	Frequency of Changes Participated in by Private Sector			
	Changes Associated with High-Involvement HS Centers		Changes Associated with Low-Involvement HS Centers	
	f	%	f	%
Background	6	35.3	5	16.7
Idea-Proposal	2	11.8	1	3.3
Support for Change Adoption	7	41.2	4	13.3
Authorization	2	11.8	1	3.3
Resource-Fund Provision	3	17.6	1	3.3
Execution	4	23.5	1	3.3
Support, Cooperation During Change Execution	9	52.9	7	23.3

N High Involvement = 17 (100%)
N Low Involvement = 30 (100%)

SUMMARY

This chapter has dealt with the question of how Head Start was involved in the process of institutional change. The data and analyses indicate that there are clear patterns in the way Head Start was involved as well as in the concomitants of its involvement. These findings may be summarized as follows:

1. When Head Start was involved in the process of institutional change, it was almost always involved in more than one stage of the change process.

2. As expected, Head Start was involved in the background, idea proposal, support for change adoption, and support during change execution stages and far less in the authorization and execution stages of the change process.

3. Head Start has generally been actively involved in encouraging the process of institutional change.

4. Changes directed toward Mexican-Americans and parents were associated with high Head Start involvement in change proportionately more often than with low Head Start involvement.

5. Changes were more often opposed in cases when Head Start was highly involved than when it was involved to a low degree.

6. CAA's and private citizens participated in the processes of change in ways parallel to Head Start, particularly when Head Start was highly involved.

The following chapter discusses the relative influence of selected Head Start characteristics on the nature and extent of Head Start's involvement in change.

CHAPTER VI

THE RELATIONSHIP OF HEAD START AND COMMUNITY CHARACTERISTICS TO INSTITUTIONAL CHANGE

PURPOSE

The purpose of this chapter is to describe the results of analyses dealing with the question:

> What were the relationships of selected Head Start and community characteristics to institutional change?

It has been found that Head Start has been influential in the process of institutional change, and the nature of Head Start's involvement has been described. The attention of this inquiry is directed toward knowing if the degree of parental participation in Head Start and the type of agency delegated to run local Head Start programs were influential with respect to the degree of involvement of Head Start in the change process, the kinds of functions Head Start performed in the change process, and how these functions were discharged. Answers to questions of this type may help to anticipate how different types of Head Start centers will influence local institutions and to plan what types of Head Start characteristics should be encouraged to achieve certain institutional impacts.

As indicated previously and in the section immediately below, we do not have a high order of confidence in the accuracy of the information describing the level of parent participation which came from self-reporting questionnaires rather than direct interviews or objective observation. Therefore, the findings and conclusions relating this characteristic of Head Start to institutional change processes must be considered tentative.

In addition, consideration is given to a number of other environmental factors, including the availability of federal funds and civil rights activities, which also help to explain some of the institutional changes that have been identified.

ANALYTICAL FRAMEWORK

Two characteristics of Head Start centers received the most attention in this analysis: level of parent participation in centers and type of delegate agency. The level of parent participation (high or low) was determined by utilizing data in the Head Start Census concerning the number of professional and non-professional staff and the method of staff selection.[1]

Information concerning the nature of the agency delegated Head Start was also obtained from the Census reports and verified by the field staff. Three categories were utilized: (1) public school systems; (2) "new" agencies, such as local Community Action Agencies, neighborhood organizations, and single-purpose agencies; and (3) "traditional" agencies, such as social service institutions, settlement houses, and churches but excluding public schools. A fourth category, termed "mixed," was used for classifying communities having several types of Head Start delegate agencies.

These two characteristics--type of delegate agency and level of parent participation--were chosen for attention because there were data descriptive of them and, at least to some extent, they can be influenced by national policy. Additionally, there has been a good deal of professional, administrative and popular speculation about the merits and impacts of parental participation and particular types of delegate agency involvement.

Three simple indications of Head Start's influence, or involvement, were selected. The first measure, "degree of involvement" of Head Start in the change process, is based on the number of stages in the change process in which a Head Start center participated. As indicated in previous chapters, those centers mentioned as participating in at least four of the possible seven stages of change were classified as "high" in their "degree of involvement" in the change process. Those centers that participated in three or fewer stages of the change process were classified as "low." Involvement by a center in a given stage was counted only once regardless of how often it may have been mentioned by respondents. A second measure of involvement concerned which of the seven stages of the change process Head Start was reported to have participated in. Last, concern focused on how Head Start was involved in institutional changes--actively or passively.

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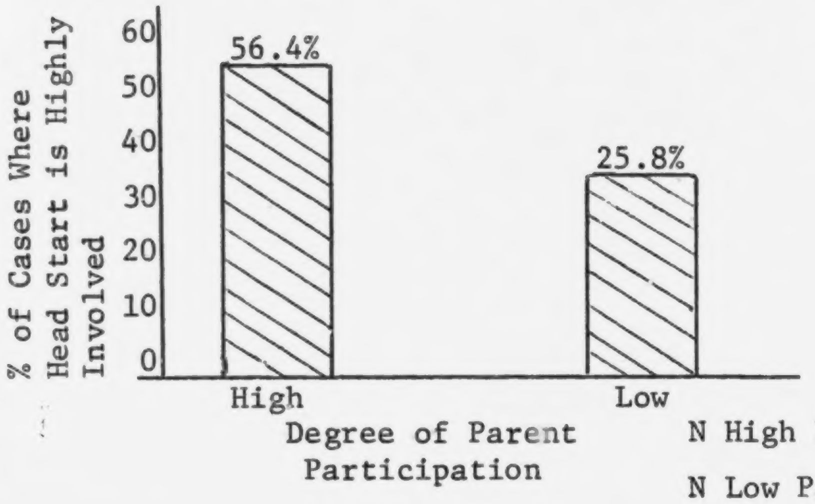
[1] See Appendix D for a discussion of development of this variable.

THE RELATIONSHIP OF PARENT PARTICIPATION IN HEAD START CENTERS TO HEAD START'S ROLE IN THE INSTITUTIONAL CHANGE PROCESS

An important concept in the Head Start philosophy is that of parent participation in the organizational structure of local Head Start centers. To understand how this concept might relate to the impact process, the centers in the 42 communities studied during Phase II were classified as high or low in their degree of parent participation and comparisons were made to determine if there were differences in the ways these two groups influenced institutions. The first question posed is:

> What is the difference in the degree of involvement in the change process of Head Start centers with high and low parent participation?

As indicated in the graph below, Head Start centers with high parent participation were highly involved in change (involved in four or more stages of the change process) much more often than those with low parent participation. Head Start was highly involved in approximately 56 percent of the changes studied when the level of parent participation was also high. Head Start was highly involved in the change process in only 26 percent of the cases when the level of parent participation was low. Since these differences are statistically significant, there does seem to be a relationship between the degree of parental participation in Head Start centers and the extent of centers' involvement in the institutional change process.



N High Participation = 16 (100%)

N Low Participation = 31 (100%)

GRAPH 4: Percent of Cases Where Head Start is Highly Involved in the Change Process According to Degree of Parent Participation

Having determined that Head Start centers with high parent participation levels were more highly involved in the changes as a whole, comparisons were made to answer the question:

> Was there a difference in the functions performed during the change process by Head Start centers with high as compared with low parent participation?

It was found that in most cases Head Start centers performed the background, support for change adoption, and cooperation during change execution functions regardless of parent participation level. Head Start contributed to change by carrying out these functions in at least 75 percent of the cases with high parent participation centers and in at least 65 percent of those with low. However, when parent participation was high, Head Start also participated substantially (in 56 percent of the changes) as "idea proposer," or initiator of change, whereas this function was only infrequently performed (in only 23 percent of the changes) by Head Start centers with low parent participation. Table 16 shows the extent of involvement at each stage by each type of center. High parent participation centers served as authorizers and executors of change significantly more often than did low parent participation centers. However, both high and low parent participation centers performed less frequently in these functions than in the idea-proposal function. Thus, not only did its degree of parent participation make a difference in a Head Start center's level of involvement in change but also in the kind of involvement, or the functions it performed, within the change process. High parent participation centers were more highly and more centrally involved in change than those in which parent participation was low.

Comparisons between high and low parent participation centers also showed differences in the ways they performed their functions. In fulfilling their background functions, both high and low parent participation centers served primarily to focus community attention on the need for change--by setting an "example" and by intentionally stimulating a "psychological climate" for change. However, as shown in Appendix Table 0-1, low parent participation centers were mentioned much more exclusively as functioning by means of "example" (in 92 percent of the cases as opposed to only 64 percent for "highs"). High parent participation centers, on the other hand, were more often mentioned as serving through "organizational" means to create a background environment conducive to change (in 50 percent of the cases as compared with only 12 percent for "lows"). It would seem that when Head Start involved the poor (the parents) in its organizational structure, this structure in turn had a tendency to become a vehicle through which Head Start contributed to the background for change. In contrast, an absence of such high parent participation led to a less active role as a "contributor by example."

TABLE 16

Extent of Head Start Involvement in Each Stage of Change Process According to Parent Participation Level

Stages in Change Process	Number of Cases			
	High Parent Participation Centers		Low Parent Participation Centers	
	f*	%*	f*	%*
Background	13	81.3	24	77.4
Idea-Proposal	9	56.3	7	22.6
Support for Change Adoption	12	75.0	20	64.5
Authorization	4	25.0	0	0.0
Resource-Fund Provision	4	25.0	2	6.5
Execution	6	37.5	4	12.9
Support, Cooperation During Change Execution	13	81.3	21	67.7

N High Parent Participation = 16 (100%)

N Low Parent Participation = 31 (100%)

* Frequencies and percentages do not include cases where it could not be ascertained (NA) if Head Start was involved or not.

In fulfilling their other functions of support for change adoption and cooperation during change execution, both high and low parent participation centers contributed predominantly by direct, active methods of participation. This occurred in at least 85 percent of the cases where parent participation was high and 81 percent where parent participation was low. Also, there were no statistically significant difference between the ways high and low parent participation centers performed their functions.

Finally an analysis was conducted to answer the question:

> Was Head Start modified programmatically and structurally as a result of its involvement in changes in outside institutions?

The following examples indicate the ways in which Head Start has itself experienced change as a result of its involvement in a change in an outside institution.

> --A southern health department enlarged its well-child clinic and requested that it be given an opportunity to provide health examinations and care to Head Start children. Head Start agreed to provide limited funds to the health agency for examination and treatment of the Head Start children. The health-care component of Head Start became a part of the operation of the health agency; the Head Start nurses became, in effect, health agency employees, and Head Start medical records became a part of the health agency's record system.

> --Head Start conducts pre-service and in-service training for health aides employed not only in Head Start, but in the community's public and private health institutions as well. This arrangement has resulted in two important impacts on Head Start. First, increase in the use of these aides outside Head Start has necessitated an enlargement of Head Start's training staff and ancillary personnel. Also, Head Start's increasingly close relationship with the outside agencies has brought about an improvement in coordination of health services for Head Start clients.

> --Since the public school system implemented its teacher aide project it has hired a number of Head Start aides. Employment as an aide in a regular school classroom is viewed by Head Start and the aides themselves as a promotion. However, this arrangement has proven to be somewhat inconvenient for the Head Start program, for it depletes Head Start's supply of trained, experienced aides and necessitates continuous recruitment and training of new aides for Head Start.

Table 17 depicts the frequencies of Head Start centers with high and low parent participation indices that were affected by the institutional changes studied. In examining the differences in the degrees to which Head Start was itself affected by the change, there was no statistically significant difference between centers with high and low parent participation.

TABLE 17

Relationship of Degree of Parent Participation to Effects of Change on Head Start Organizational Structures and Programs

Head Start Affected	Degree of Parent Participation			
	High		Low	
	f	%	f	%
Yes	11	68.8	15	48.4
No	5	31.2	16	51.6
Total	16	100.0	31	100.0

Summary

The analyses indicate that Head Start centers with a high degree of parent participation were involved during more functions within the change process than were centers where parent participation was low. In addition, high parent participation centers served to create a background conducive to change. However, the level of participation by parents in the Head Start program was not related to Head Start's efforts in encouraging local private citizens to support the institutional changes. It was also determined that level of parent participation in Head Start had no bearing on whether modifications in Head Start centers were related to their involvement in external change processes.

RELATIONSHIP OF TYPE OF HEAD START DELEGATE AGENCY TO HEAD START'S ROLE IN THE INSTITUTIONAL CHANGE PROCESS

Head Start centers are directed locally, with the national Head Start organization delegating authority to various types of local community institutions. Primary among these are the public school systems and the new (CAA or single-purpose) agencies which have the responsibility and authority for directing the local Head Start centers.[1] Being different types of institutional systems, it is reasonable to assume that these delegate agencies would run Head Start centers differently and have different effects on Head Start involvement in community change. Thus, an analysis was made to determine if Head Start centers functioned differently in the change process depending on their type of delegate agency.

As to their degree of involvement (high or low) in the change process, no significant difference was found. Graph 5 shows that Head Start centers run by public school systems were highly involved in the change process about as often as those run by new agencies

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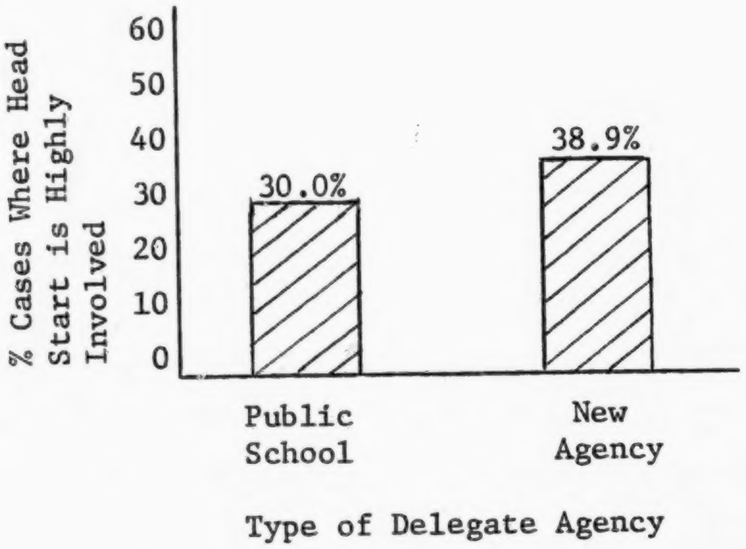
[1] Originally, four types of delegate agencies were specified: public school systems, "new" agencies, traditional agencies, and "mixed" (a combination of two or three agency types in a community). However, N's for "traditional" and "mixed" categories were so small (3 and 6, respectively) that findings for them were meaningless. Thus they were omitted from analysis and the following discussion is limited to the 38 remaining cases: 20 with public school and 18 with "new" delegate agencies.

(in 30 percent and 39 percent of the cases, respectively). It seems that Head Start's overall degree of involvement in change was not related to its type of delegate agency.



N Public School = 20 (100%)
N New Agency = 18 (100%)

GRAPH 5: Comparison of Percent of Cases Where Head Start is Highly Involved in Change Process--for Centers with Public School and "New" Delegate Agencies

Regarding the kind of involvement in change (the functions Head Start performed within the change process), both public school and new agency Head Start centers served predominantly in the functions of background, support for change adoption, and cooperation during change execution. In at least 60 percent of the cases with public school centers and 61 percent of those with new agency centers, Head Start served in a supportive capacity to facilitate the progress of change (see Table 18). Only infrequently did a Head Start center fulfill the more central functions of change (idea-proposal, authorization, resource-fund provision, and execution). Thus, both public school and new agency centers followed the usual Head Start

TABLE 18

Extent of Head Start Involvement at Each Stage of the Change Process According to Type of Delegate Agency

Stage in Change Process	Number of Cases			
	Public School Delegate Agencies		"New" Delegate Agencies	
	f*	%*	f*	%*
Background	15	75.0	16	88.9
Idea-Proposal	6	30.0	6	33.3
Support for Change Adoption	12	60.0	13	72.2
Authorization	0	0.0	2	11.1
Resource-Fund Provision	0	0.0	3	16.7
Execution	0	0.0	5	27.8
Support, Cooperation During Change Execution	16	80.0	11	61.1

N Public School centers for each stage = 20 (100%)
N New Agency centers for each stage = 18 (100%)

* Nine cases where Head Start centers had "traditional" or "mixed" delegate agencies are excluded. Percents are based on 38 (not 47) cases. Frequencies do not include cases where it could not be ascertained (NA) if Head Start was involved or not.

pattern of high supportive involvement in the change process with little participation in those stages more central to the change process. Regardless of type of delegate agency, Head Start functioned as a "facilitator of change" rather than as a "changer" itself.[1]

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[1] Although some differences in performance by new and public school Head Start centers did appear these differences were not statistically significant.

Generally, the Head Start programs performed the same functions and in the same ways, whether they were delegated to public schools or "new" agencies. In contributing to the background for change, both new agency and public school Head Starts served to focus community attention on problems that needed to be solved. As indicated in Appendix Table P-1, Head Start performed this function by creating a psychological climate for change and by setting an example. Head Starts' delegated to public schools were cited as contributing to the background stage by setting an example significantly more frequently than other Head Start centers.

Likewise, in their functions of support for change adoption and cooperation during its execution, Head Start centers delegated to both types of agencies performed similarly. Both public school and new agency centers showed their support for change adoption and execution almost exclusively by active, direct methods of advocacy and participation. In approximately 81 percent of all cases involving public school and new agency centers, Head Start became actively, directly involved in facilitating change adoption and execution (see Appendix Tables P-2 and P-3).

Thus, not only did the type of delegate agency have no relationship to the degree of Head Start involvement in change or on the functions Head Start performed in the change process, but the ways in which Head Start centers fulfilled these functions were also similar, whether they were run by the public schools or by new agencies.

Finally, an analysis was made to ascertain the degree to which public school and new agency Head Start centers were affected or altered by the change. Again, the type of delegate agency made no statistically significant difference (see Table 19).

TABLE 19

Relationship of Delegate Agency Type to Effects of Change on Head Start's Organizational Structures and Programs

Head Start Affected	Delegate Agency			
	Public School		"New" Agency	
	f	%	f	%
Yes	8	40.0	10	55.6
No	12	60.0	8	44.4
Total*	20	100.0	18	100.0

N = 38

* Total does not include 9 cases where Head Start delegate agency was "traditional" or "mixed." Thus, total N is 38 (not 47) cases.

Summary

The type of delegate agency chosen to run a Head Start center was found to have had little relationship to that center's involvement in change, with respect to its overall level of involvement in the change, particularly the kinds of functions it performed within the change process, and the degree to which it was itself affected by the change. In the impact cases studied, Head Start became involved in changes within the community in the same ways and to the same degree regardless of whether the delegate agency was the public school system or a new (CAA or single-purpose) agency. There was a slight difference, however, in the extent to which new agency and public school Head Start centers were able to serve as effective examples for change. Although both types of Head Start centers were cited frequently as examples, the Head Start centers delegated to public schools were reported as such significantly more often.

OTHER VARIABLES

Many factors are at work nationally and locally to produce change, and together these factors seem to have been responsible for a general revamping of traditional institutional and personal attitudes toward the poor, toward minority groups, and toward seeking solutions to their problems. There is now, generally, an attitude toward the poor and the minorities that implies that something may have been lacking in the services and opportunities for the poor rather than solely in the poor themselves. This attitude is manifested throughout our news and communications media, in professional periodicals and publications, and in much of our literature. The new attitude stems from many sources, not the least of which is the civil rights movement. Since the early 1960's there has been increasing focus on desegregation in housing, schools, business establishments, transportation facilities, and employment.

Simultaneously, the causes of poverty have received increasing attention from social scientists and educators as evidenced by the volume of research and written materials emanating from leaders in these fields through their professional journals. For example, 8 of 10 articles in a recent issue of a national educational journal focused on some facet of education for poor and minority children.

Thus, most of our local Head Start programs have been operating in a climate conducive to change. Meanwhile, funds have been made available by state and federal agencies to make local institutional change possible. As the following discussions point out, Head Start has contributed to this climate for change in many communities by making itself visible and serving as a demonstration of how innovative ideas can be translated into workable programs.

Visibility of Local Head Start Program

The cases of change studied indicate that a strong relationship exists between Head Start visibility in a community and its impact on community institutions. In nearly all cases where changes were stimulated by Head Start staff requests or Head Start's example, the Head Start program appeared to have achieved a rather high degree of visibility in the community. In many instances Head Start has become visible to the institution making the change by:

--establishing a working or organizational relationship with the institution,

--being delegated to the institution, or

--generating active parental involvement in community affairs which in turn focused attention on Head Start.

In some communities new agency Head Starts became visible to established institutions as a result of their working relationships:

--An "Extended Kindergarten" program in ________was conceptualized and developed by a school official who serves as a member of the Head Start Policy Advisory Committee. The purpose of "Extended Kindergarten" is to provide a full-day educational experience for five-year-old children in two low-income areas of the city. The program was designed to upgrade the education for poor children and provide a follow-up to their Head Start experiences prior to the time they enter first grade. The school official who originated this program was reported to have become a "chief mover" for programs to enhance educational achievement of low-income pupils. In her capacity as a member of the Head Start PAC, she works closely with the CAA's Head Start program.

Head Start concepts became visible to institutions delegated to operate Head Start centers:

--The public school system in _______ has recently developed an "Experimental Kindergarten" in the city's poverty areas. The program utilizes a special curriculum designed to compensate for the prevalent deficiencies in cognitive and verbal abilities among poor children. School officials reported that these deficiencies were brought to their attention by the school system's Head Start program, particularly after it was discovered that Head Start children performed much better in school than

> poor children who had not been in Head Start. When ESEA, Title I funds became available, the school system was able to provide an early learning program for low-income children.
>
> --The public school system operating Head Start programs employed some of its regular classroom and kindergarten teachers in Head Start for short periods of time. While serving in Head Start, the teachers became oriented to the Head Start concepts and accustomed to working with teacher aides. As a result, the teachers had returned to their regular classrooms with new ideas, goals, and attitudes toward the poor, and had requested teacher aides in their own schools and classrooms.

In some localities, Head Start Policy Advisory Committees have served as an instrument through which poor parents met, discussed issues, and developed their latent leadership qualities.

> --An issue involving the school system's lack of attention to Head Start children so enraged Head Start parents that they started requesting audiences with the school superintendent. When he would not grant them an audience as a group, the Head Start parents reported the incident to the newspaper, thereby deliberately calling attention to the problem.

Studies of several other communities reveal situations in which Head Start programs were not so visible and were, in fact, quite obscure. Changes had occurred in these communities, both in health and educational institutions, but few of the changes appeared to have been designed for the poor, and, reportedly, none had been actively stimulated or supported by the local Head Start programs.

> --The Head Start program is quite small in relation to the poverty community's size; and it has little communication with other community organizations, with the exception of the medical school which provides health services. Medical school personnel have tried to have some of the Head Start children referred to the new mental health clinic, for they feel that a few of the children may be seriously disturbed. Head Start staff, however, is reluctant to confront the parents with this information about the children because of the stigma they attach to mental illness.

> --A Head Start program in the South staffed by blacks is reluctant to initiate contacts with local agencies which represent to them the white establishment. Parents and staff have a strong desire for independence and an almost equally strong fear of Head Start being taken over by another local group if they assert themselves to any extent. This Head Start program has not been involved in changes, although some changes have occurred, particularly in the area of mental health. Head Start has few contacts, apparently, outside its own neighborhood except with some of the black private physicians who provide health care for the children.

Thus, there are strong indications that a relationship exists between Head Start's involvement in the change process and its level of visibility in the community. Where Head Start has achieved what seems to be a high degree of visibility, Head Start has been highly involved in change. In contrast, Head Start programs that have preferred to remain obscure have not been directly, or even indirectly, involved in bringing about institutional changes.

Civil Rights Activity

Civil rights activities have been conspicuous in many communities studied and have been at least partially responsible for some significant changes. The tactics of civil rights groups have varied; some have presented requests for change through established and traditional channels, while others have used more militant tactics. Occasionally there was a diffusion effect wherein ghetto riots throughout the country caused changes in peaceful communities in order to prevent riots locally.

> --A school system in a large northwestern city was alerted by a civil rights organization that de facto segregation existed in the city schools and that steps should be taken to eliminate it. The board of education responded by appointing a study committee to gather statistics of alleged discrimination and make recommendations for equalizing educational opportunities in the city. The comprehensive study made by the committee revealed inequities in the school system and

recommended an overhaul of the entire system. Many of the recommended changes were incorporated into a specialized inner-city program developed with the use of federal funds.

--Ghetto rioting during the summers of 1965 through 1968 gave the school system cause to study the factors contributing to the unrest and to reflect on the school system's role in counteracting them. The superintendent of schools appointed a committee to study the problems and recommend solutions. Committee members represented, among others, some leaders of the black community who were Head Start parents and staff members. Recommendations made by the committee and implemented by the school system included free lunches and breakfasts and employment of teacher aides and home-visitor/social work aides from the black community.

--Fear of race riots motivated the school system to seek ways of maintaining peace in this northeastern city, which derives economic benefit from tourism. Community leaders and school officials met with Head Start and antipoverty program leaders to discuss ways of meeting the needs of the poor. As a result, remedial programs and free-lunch programs were developed for ghetto school children; black social workers and aides were hired to work with ghetto families.

Availability of Federal Funds

Regardless of the role of Head Start or any other motivating or environmental factor, most school system and health agency respondents stated that they could not have made the changes they did without financial help from outside the community. Even when Head Start was directly responsible for stimulating a change or for establishing a new program that was assumed by an older institution, federal and state funds were generally what enabled the institution to carry out the change. Interview respondents representing public schools and health agencies stated:

> We cannot possibly ask local property owners to provide more money. They are overtaxed already and have voted down two bond issues. If we did not have ESEA funds,

> we could not have employed our teacher aides and bought all the special equipment we have for the remedial program.
>
> The clinic for migrant workers in _____ is a fine thing, but local people won't finance it, at least not until we've had it awhile. It is funded almost entirely by the federal government.
>
> We have wanted a free lunch program for decades and the children need it. We could not implement the program until federal funds became available.

SUMMARY

The data and analyses presented in this chapter indicate tentatively that the degree of parent participation is related to Head Start's involvement in institutional change. It appears that Head Start centers with high parent participation levels (as defined for purposes of the project) are more centrally and actively involved in the institutional change processes than are centers with low parent participation.

We have considerably greater confidence in the delegate agency data and the analyses utilizing this variable. These analyses indicated that there was little relationship between the type of agency to which a Head Start program is delegated and the Head Start's involvement in institutional change.

High visibility and a willingness to relate to other organizations appear to be two other factors related closely to the extent that Head Start influences other institutions. Many Head Start programs are located in communities where there is an environment conducive to change to benefit the poor. Factors contributing to this environment have included civil rights activities, influence of leaders in the social sciences and education, and the availability of federal funds for educational and health projects for low-income children.

CHAPTER VII

A COMPARISON OF HEAD START INVOLVEMENT WITH EDUCATIONAL AND HEALTH CHANGES

PURPOSE

The presentation has so far principally considered institutional changes as a whole without distinguishing whether they were primarily education or health related. It was earlier indicated that of the 47 case studies of changes investigated, 32 were in the educational area and 15 were health related. In three communities, health-related changes were made by public school systems rather than public health agencies. The narrative reports in Appendix R trace the histories of specific changes in both these areas. The purpose of this section is to present the results of analyses that distinguish between health and educational changes. The question asked is:

> Were there differences in the extent and type of Head Start involvement in the educational as compared with the health area?

METHODOLOGY

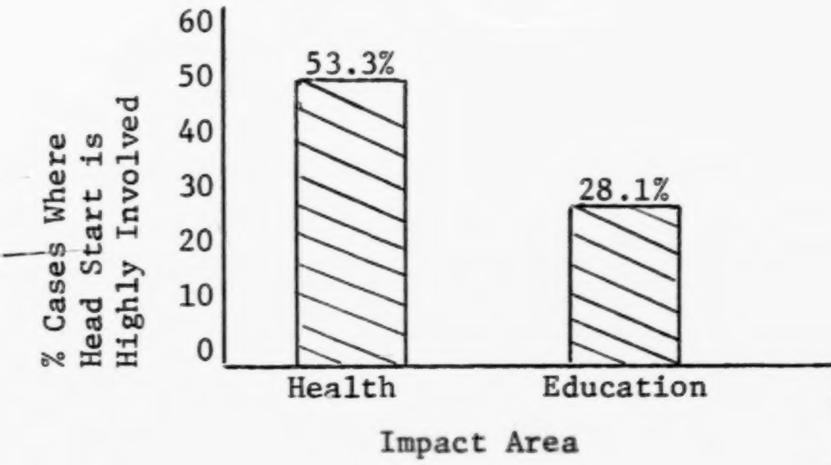
Changes studied were classified as either educational or health related in keeping with criteria described in Chapter III (i.e., the nature of the change itself rather than the type of institution making the change). The same types of analyses that were conducted for the changes as a whole were then conducted for each group of changes and the results presented comparatively.

FINDINGS

Extent of Involvement in Change

As indicated earlier, Head Start centers were classified as "high" or "low" in their degree of involvement in change depending upon the number of stages in the change process in which they participated.

It was found that Head Start was proportionately highly involved much more often in health than in educational changes. Graph 6 shows that in 53 percent of the health changes, in contrast to only 28 percent of the education changes, Head Start was "high" in its degree of involvement (frequency of participation) in the change process.



N Health Impacts = 15 (100%)
N Education Impacts = 32 (100%)

GRAPH 6: Percent of Cases Where Head Start was Highly Involved in Health and Educational Change Processes

Kind of Involvement (Functions Performed)

Although there is a difference in the degree of Head Start involvement in health as opposed to education changes, no such differences were found regarding the kind of involvement or the functions performed by Head Start in the change process. Head Start centers involved in both health and education impacts served primarily in the secondary functions of contributing to the background for change, supporting the adoption of change, and cooperating during change execution. This type of Head Start participation occurred in at least 73 percent of the health changes and 63 percent of the educational changes (see Table 20). The functions of change-proposer authorizer, and resource-provider, were infrequently fulfilled by

Head Start whether the change was in the health or in the education area. In a significantly greater proportion of the changes in the health area, Head Start served as the executor of a change. Generally, though, Head Start was an "aider and abetter" within the change process, rather than a "changer" itself.

TABLE 20

Extent of Head Start Involvement at Each of Seven Stages of Change Process According to Area of Change

Stage in Change Process	Number of Cases*			
	Health Area		Education Area	
	f*	%*	f*	%*
Background	11	73.3	26	81.3
Idea-Proposal	7	46.7	9	28.1
Support for Change Adoption	12	80.0	20	62.5
Authorization	3	20.0	1	3.1
Resource-Fund Provision	4	26.7	2	6.3
Execution	6	40.0	4	12.5
Support, Cooperation During Change Execution	13	86.7	21	65.6

N Health for each stage = 15 (100%)
N Education for each stage = 32 (100%)

*Frequencies and percentages do not include cases where it could not be ascertained (NA) if Head Start was involved or not.

How Functions Were Fulfilled (Methods or Ways Used)

The ways in which Head Start performed its functions were generally the same, whether the change was in the health or in the education area. Head Start centers involved in both health and educational impacts contributed to the background for change primarily by increasing the community's awareness of the existence of problems needing solution. In 64 percent of the health and in as many as 89 percent of the education changes, Head Start helped to awaken communities by setting an "example" through its own concern with community problems. In 64 percent of the health and 57 percent of the education impacts, Head Start intentionally tried to arouse community interest and create a "psychological climate" conducive to change (see Appendix Table Q-1).

In fulfilling their other functions of support for change adoption and cooperation during change execution, almost all Head Start centers contributed primarily in direct, active ways to facilitate change in both health and education areas (in at least 85 percent of the health and 81 percent of the education changes). In addition to the predominant "direct-action" method, Head Start also showed its support during change execution by encouraging private citizens to participate in 62 percent of the health and 43 percent of the education impacts. Various methods used by Head Start and the frequency of their use to support adoption and execution of change are presented in Appendix Tables Q-2 and Q-3.

Head Start Affected by Change

There was a tendency for Head Start centers to be affected or altered by more of the health changes (67 percent) than the education change (50 percent); however, this difference was not great enough to be statistically significant (see Table 21).

TABLE 21

Relationship of Health and Educational Changes to Changes in Head Start's Organizational Structures and Programs

Head Start Affected	Area of Change			
	Health		Education	
	f	%	f	%
Yes	10	66.7	16	50.0
No	5	33.3	16	50.0
Total	15	100.0	32	100.0

SUMMARY

The analysis indicates that Head Start was involved "highly" in a greater proportion of health than educational changes. Once involved, however, the ways in which functions were fulfilled and the degree to which Head Start was itself affected by the change were generally the same regardless of whether the changes were in the health area or were education-related.

CHAPTER VIII

CONCLUSIONS

FINDINGS

Surveys in 58 communities with full-year Head Start programs revealed that in every community many changes in public school and health organizations had occurred. Most of these changes were consistent with Head Start philosophies and program goals. These identifiable changes in institutional policies and programs represented tangible evidence of increased concern with and sensitivity to the needs of the poor. Surveys in communities with little or no Head Start experience revealed few comparable changes.

Intensive studies in 42 of the 58 sample communities revealed that individuals and groups associated with local Head Start programs had generally played important roles in bringing about educational and health changes. They were involved most frequently in the background and supportive stages of the change process. In most cases, Head Start exerted its influence both by setting an example and by involving itself actively in the change process.

Some Head Start centers were more highly involved than others in the institutional changes studied. Head Start was highly involved more frequently in health than in educational changes and when there was opposition to the changes being sought. Also, the high involvement of Head Start was associated with the active participation of CAA's and private citizens in the change process.

Analyses were conducted to determine if certain characteristics of Head Start, specifically the level of parent participation and the type of agency to which the program was delegated in a community, were related to Head Start's involvement in the change processes. It was found that centers with high levels of parent participation were involved with more stages of the change processes and were more actively involved than the other centers. It does appear that the level of parent participation in centers was positively related to Head Start's involvement in the institutional change process. The type of agency to which Head Start was delegated, however, did not generally appear to make a significant difference in terms of Head Start's involvement in the institutional change process. Only one significant difference was evident: Head Starts delegated to public schools, rather than to new agencies, were more frequently identified as an example for the changes studied.

Various environmental factors supported the attainment of Head Start's community goals. The principal factor was the availability of federal funds for new programs, particularly for poor children. Another was a community awareness and willingness to help the poor and minority groups stemming at least partially from civil rights activities and the concern of leaders in health and educational fields.

CONCLUSIONS

It is important to place the findings of this study in perspective so that their significance may be fully appreciated. One tends to forget that educational and health institutions have not been noted for their flexibility, responsiveness, or access to control by the public, particularly the poor. These institutions have been and continue to be largely controlled by professionals, and until only recently, the sanctity of the professionally devised policy or program was not open to question. Public school boards tended to be dominated by professional experts and administrators. These institutions have not been particularly concerned with the child from the poor family, the disadvantaged child or the child from a minority culture. Indeed, educational and health institutions have been the bastions of "traditional" views, the protectors, teachers, and disseminators of middle-class values and virtues.

This study indicates that in less than half a decade, a remarkably short period, there have been many widespread and fundamental changes in these institutions. One may say that they have not changed enough, that they are not yet truly responsive to or controlled by the people they serve, that their technology is not adequate to the needs of their new-found clientele (the poor and the minorities) and that the changes in these local institutions will last only so long as they are supported by federal funds. All these statements have substantial elements of truth. It is nevertheless true on a national basis, that concern for the educational and health needs of the poor, and particularly the children of the poor, have become manifest in specific and concrete policy and program changes in local educational and health institutions. It is easy today to accept these changes and to lament that there is still so much to do. In 1960, however, it would have been visionary to predict that:

> --Public schools and medical facilities would be putting enormous emphasis on the particular needs of the poor and minorities.
>
> --Schools and health institutions would have created new important paraprofessional roles and that relatively untrained, "uncertificated," "unlicensed" neighborhood people would be working in these positions.
>
> --Schools and health institutions would be controlled, at least to some exent, by the poor--the least articulate, trained and professional group in the society.

One has only to compare the educational literature of ten years ago with today's to know that important changes have occurred. But this project indicates that the changes have not been confined to the researchers, the experimenters or the "progressives." On a national basis, in large cities and small, in urban areas and rural, educational and health institutions have changed in fundamental ways. They have changed from a traditional concern solely with middle-class values and the middle-class child so that their programs widely reflect the philosophies and goals of Project Head Start--that is, to encourage and assist poor children and their families to develop their capabilities fully.

One can speculate about the many possible factors and forces that have contributed to the remarkable changes in educational and health institutions. And one would be remiss indeed to overlook the fact that these important changes have taken place in a decade of fundamental change in many values, mores and institutions. This project does indicate, however, that these significant health and educational changes are closely associated with the existence and activities of local Head Start programs. That is not to say that the changes were caused by Head Start or are associated solely with Head Start. The evidence does indicate that Head Start has been closely involved with and influential in bringing about these changes.

If, as this project indicates, Head Start has influenced the mainstream, traditional educational and health institutions to share its philosophies and many of its programs and procedures, that is a fundamental achievement. It is a fundamental achievement because these traditional local institutions carry the weight of the responsibility to help poor families. The resources of these institutions are many times greater than Head Start's, their contacts with the poor are potentially far greater and their impacts can be continuing. It is a fundamental achievement not only because the potential benefits are so large but because the investment in achieving these changes has been relatively small. In fiscal year 1969, for instance, the Head Start budget was approximately $340 million, only slightly more than the total public education budget (excluding higher education) in the State of New Mexico, a state with a total population of only a million people. The Head Start investment appears to have had enormous leverage.

It is interesting to reflect on the nature of the programs that have had this great influence. This research project has not been concerned particularly with Head Start itself because it has concentrated on its impacts. It is commonly known, however, that while programs vary widely in content and approach, most share a concern for all aspects of the child's development; they deal with small groups of children in a concerned way in local settings. They employ nonprofessionals in their operation, and, to a greater or lesser extent, involve the local parents. They have generally not been militant, though Head Start staff and parents have actively sought to improve schools and health facilities. In terms of influencing traditional institutions, Head Start has been a timely program, it has been visibly appealing, and it has generally been sufficiently non-threatening so that its concepts could be widely adopted by existing institutions. Head Start has indeed been a successful strategy in widely achieving the goal of modifying local institutions so that they are more responsive to the needs of the poor.

APPENDIX A

LETTER TO POTENTIAL TELEPHONE INTERVIEW RESPONDENTS

Under contract to OEO, our firm is engaged in a national evaluation of the community impacts of Project Head Start. This research has been designed to include the comments and observations of persons who have had substantial experience in this area. Mr. Charles Jones of Project Head Start has suggested to us that you would have valuable insights into the relationships with which we are concerned. Accordingly, we would like to draw upon this knowledge and compensate you for your assistance.

Basically, we are seeking your observations regarding the effects of Head Start on various communities with as many examples of institutional change as possible, such as:

> Changes in policies, activities, curricula, personnel standards, salary schedules, etc., of school systems, to bring them more in line with Head Start approaches.
>
> Increased employment of nonprofessionals, particularly by child-serving institutions and agencies.
>
> Changes in policy, philosophies or goals of various service organizations, such as United Fund, health agencies, etc., reflecting an increased concern with disadvantaged children.
>
> Conflicts stemming from any aspects of Head Start programs resulting in community or organizational change of a negative character, vis-a-vis the stated goals and objectives of Head Start.

Mr. Richard Moss or Mrs. Nancy Sandusky will be contacting you by telephone during October to discuss these matters. The fee provided for your assistance will be $25.00. To permit scheduling of our call at a time most convenient to you, please fill out and return the attached postcard now. Should it be more convenient for you to call us directly, please call collect for Mr. Moss or Mrs. Sandusky at the number listed above or at (505) 268-3328.

Sincerely,

RLM:eml

Richard L. Moss

Enclosure

APPENDIX B

GUIDE FOR TELEPHONE INTERVIEWS

Name of consultant: ______________________________

Date of call: ______________ Telephone number: ________

Interviewer: ______________________________

Time call begun: ______________ Time ended: __________

This is ________________ of KAI calling about the interview for the Head Start Impact study. Is this a convenient time to talk?

If NO: When would be a good time for me to call back? Would it be all right with you if we recorded this conversation so that we don't lose any of the information?

First, I'd like to ask you a few background questions.

1. How long have you been serving as a Head Start consultant?
2. How many community Head Start programs do you know pretty well? That is, programs in how many cities?
3. Now can you give me a specific case story of a change in a community organization that came about because of the impact of the Head Start program?

If not mentioned in the narrative, probe for:

Name of city in which the events took place

Approximate date of the change

Specific nature of the change

Level at which the Head Start program was engaged in the process of change

Was it one Head Start center that was involved in bringing about the change, or one delegate agency running several centers, or the city-wide Head Start or what?

Attribution

Do you think that the change can really be attributed to the Head Start program? Was the Head Start program the only active factor in the situation, or were both Head Start and the CAA active in trying to accomplish the same ends, or were there other forces as well working in the same direction? Is it possible to separate out the contribution that Head Start made in bringing about the change?

4. Do you know of another example of community change because of the Head Start program?

Same probes

5. Can you give another illustration of organizational change because of the impact of Head Start?

Same probes

6. In general, thinking of all the communities you're familiar with, would you say that Head Start programs have brought about a good deal of change or not much change? Is change in community agencies and institutions because of Head Start pretty common or fairly rare?

7. What level in Head Start has been most active in seeking change? Is it the local Head Start center, or the staff of the delegate agency that runs several Head Start centers, or the city-level Head Start people, or what?

8. Have parents' groups played an active part in stimulating change in other agencies? If YES, would these be parents' groups of a particular center acting alone, or some coordinated organization of parents' groups, or what?

9. Has Head Start had its major effect on the public schools?

10. Have there been changes in health, dental, and mental health services for children?

11. Have there been changes in the regular programs of settlement houses, community center, or other agencies that serve children?

    If YES: Have these kinds of changes taken place only if the child-serving agency has run a Head Start center, or have these agencies been affected anyway?

Detailed process of change

Which agency initiated the events that led to change? What staff members were involved? That is, staff in what positions?

Did the agency agree to the change right away, or were there episodes of conflict and resistance?

Were there any persons outside of Head Start (and not in the other agency) who put on pressure for or against the change? Did any outsiders act as brokers or mediators in bringing about the change?

About how long a time elapsed from the beginning of the interaction until the change took place?

Who was involved in reaching the final decision?

Factors that made the Head Start program effective as a change agent

What were the factors that you feel made the Head Start program effective in bringing about the change?

Factors that made the agency receptive to change

Were there any special characteristics of (the agency) that made it particularly receptive to change?

Pervasiveness of change within the agency

Are all units of ____________________ affected by the change, all units serving poor children, or only those in the direct service area of Head Start?

Stability of change

Have the changes been enacted into statute or policy?
Have adjustments been made in organizational structure to maintain the change?
Has money been allocated to keep the change going?
Or is continuation dependent on the continued good will of agency personnel?

12. Do the changes generally affect the whole agency city-wide, like the whole city's school system? Or are the changes limited to the unit of the agency (say the local school) nearest the Head Start location?

13. Is there anything else that you think we ought to know on the subject of the impact of Head Start?

APPENDIX C

Budget Bureau No. 116-R0103, Approval Expires August 31, 1968

FORM CAP-HS-52
(1-24-68)

OFFICE OF ECONOMIC OPPORTUNITY
PROJECT HEAD START

CENTER FACILITIES AND RESOURCES INVENTORY

Grant number	Center number

Center name

Center address *(Number and street, city, State, ZIP code)*

Number of weeks Center has been operating →	
Number of hours per day available for child to attend Center activities →	
Length of program (in weeks) →	

Number of –		Date this form completed		
Classes in Center	Children in Center	Month	Day	Year

Part I – STAFF AND PARTICIPANT INFORMATION

Report all individual paid and volunteer staff members involved with Center activities on a regular basis whether part-time or full-time. Report part-time and full-time as whole numbers.

	Number
A. Total number of professional staff members: (with specific college or professional training for positions they hold.)	
1. Administrators	
2. Teachers	
3. Nurses	
4. Social workers	
5. Psychologists	
6. Counselors	
7. Speech therapists	
8. Physicians	
9. Dentists	
10. Nutritionists	
11. Consultants (education, art, music, etc.)	
12. Other *(Specify)*	

	Number
B. Total number of other staff members:	
13. Teacher aides	
14. Health aides (includes medical, nurses' aides)	
15. Social services aides (includes community aides, social workers' aides)	
16. Nutritionist aides	
17. Cooks	
18. Chauffeurs	
19. Equipment construction / building maintenance	
20. Secretary / clerical	
21. Housekeeper / launderer	
22. Other *(Specify)*	

C. Number of volunteers by area in which they reside: *(Indicate the number in each category in the appropriate column)*	Immediate neighborhood	Outside communities
1. Elementary school age		
2. Junior high school age		
3. Senior high school age		
4. College and university students		
5. Adults: a. Professionals volunteering professional skills		
b. Voluntarily unemployed (retired persons, wives, etc.)		
c. Involuntarily unemployed (persons who have not been able to find work)		
6. Other *(Specify)* ______________		

D. Number of volunteers from each of the following sources: *(Indicate the number in each category)*	Number of volunteers
1. Older siblings of Head Start children	
2. VISTA	
3. Neighborhood Youth Corps	
4. Work study programs	
5. Volunteers for Vision	
6. Youth organizations (scout troops, 4-H, teen clubs, etc.)	
7. Community organizations (lodges, churches, clubs, PTA, etc.)	
8. Professional organizations (medical, dental societies, etc.)	
9. Individuals (not volunteering through any organized groups)	

E. Teacher-to-child ratio in classrooms: One to	Number of children
F. Teacher-to-child ratio including aides in classrooms: One to	Number of children

G. Teachers in the Center were selected by: *(Mark all applicable items)*

1 ☐ Center Director
2 ☐ Policy Advisory Committee
3 ☐ Group Parent Committee
4 ☐ CAP Personnel Director
5 ☐ Social Service Agency
6 ☐ Local school board
7 ☐ Education Director
8 ☐ Board of Education
9 ☐ Other *(Specify)* 7 ______________

Part II – CHILDREN SERVED BY THE CENTER

A. Indicate resources used for recruitment of children: *(Mark all applicable items)*

1 ☐ Teachers
2 ☐ Volunteers
3 ☐ Door-to-door canvassing
4 ☐ Welfare roles
5 ☐ School lists
6 ☐ Public health agencies
7 ☐ TV announcements
8 ☐ Radio announcements
9 ☐ Newspaper announcements
10 ☐ Brochure, newsletter to individual parents
11 ☐ Loud speaker truck
12 ☐ Institutions *(Specify)* ____________________

____
13 ☐ Other *(Specify)* ____________________

B. Ages of children at time of enrollment served by the Center. *(Please indicate number of boys and number of girls for each age category.)*

	Number of –	
	Boys	Girls
1. 0 – 5 months		
2. 6 months – 11 months		
3. 1 year – 1 year, 5 months		
4. 1 year, 6 months – 1 year, 11 months		
5. 2 years – 2 years, 5 months		
6. 2 years, 6 months – 2 years, 11 months		
7. 3 years – 3 years, 5 months		
8. 3 years, 6 months – 3 years, 11 months		
9. 4 years – 4 years, 5 months		
10. 4 years, 6 months – 4 years, 11 months		
11. 5 years – 5 years, 5 months		
12. 5 years, 6 months – 5 years, 11 months		
13. 6 years – 6 years, 11 months		
14. 7 years and over		

C. Children served by this Center are primarily from: *(Mark one box only)*

1 ☐ Large city – population over 100,000
2 ☐ Medium city – population 25,000 to 100,000
3 ☐ Small city, town, borough, or village – population 2,500 to 25,000
4 ☐ Densely settled, urban fringe, including both incorporated and unincorporated areas, around a city of 50,000 or more inhabitants
5 ☐ Unincorporated area of 2,500 inhabitants or more outside of an urban fringe.
6 ☐ Rural – all areas not included in the categories above

D. Number of English speaking and non-English speaking children:

	Number
1. Number of English speaking children in program	
2. Number of non-English speaking children in program	

E. Number of children served by this Center in each of the following ethnic/racial groups:

	Number
1. Caucasian	
a. Mexican – American	
b. Puerto Rican	
c. Other caucasian	
2. Negro	
3. American Indian	

	Number
4. Oriental	
5. Eskimo	
6. Polynesian	
7. Other *(Specify)*	

____

APPENDIX D

DEVELOPMENT OF PARENT PARTICIPATION INDICES

Two items on the Center Resources and Inventory report were used in developing the indices. The first item (Part I, Items A and B) deals with the number of professional and nonprofessional staff members.

A ratio of nonprofessionals to professionals was developed for each center and ratios were then placed in rank order. The half of the centers with the higher ratios of nonprofessional to professionals were considered "high," and the others "low."

The other item used was the extent to which staff members were selected by Head Start parents (Part I, Item G). When staff members were selected by parents, this was considered an index of high parent participation; when agencies selected staff, it was considered an index of low parent participation.

Centers were considered to have high levels of parent participation when both indices were high, i.e., when there was a high ratio of nonprofessionals to professionals and when parents selected the staff. Centers were considered to have a low level of parent participation when both indices were low, i.e., when there was a low ratio of nonprofessionals to professionals and when agencies selected the staff. Centers were considered to have medium levels of parent participation when one index was high and the other low.

Of the 42 communities studied, 14 were in communities defined as having high levels of parent participation; 12 as medium and 16 as low. Because there was a desire to divide each variable in two categories, the medium participation centers were subsequently combined with the lows. Thus, 14 centers were defined as having high levels and 28 as having low levels of parent participation.

APPENDIX E

DEVELOPMENT OF SAMPLE OF COMMUNITIES FOR PHASE I FIELD WORK

The Office of Research and Evaluation, Project Head Start, provided KAI with IBM cards containing information from 485 communities pertinent to the four independent variables noted above. These cards had been keypunched from the raw data, i.e., the pertinent sections of the "Center Facilities and Resources Inventory" form. It was necessary to eliminate 200 of these communities from consideration for inclusion in the sample, either because the information about the communities was incomplete (as was the case for 162 cities), the clientele was American Indian (17 cities), or the data were too diverse for classification here (21 cities). Thus 285 localities were ultimately considered for inclusion in the sample.

The matrix in Table E-1 depicts the numerical distribution of the 285 communities in each of the categories created by the four independent variables. The matrix indicates that 66% of these communities were classified as small (under 25,000 population), 18% were medium sized (25,000 to 99,999), and 16% were large (100,000 and over). Features relating to the other three independent variables are indicated below:

Parent Participation		Ethnicity of Clientele		Delegate Agency	
High	24%	Negro	40.5%	Public School	34%
Medium	44%	Anglo	40.5%	Traditional	14%
Low	32%	Spanish	19%	New	52%

From these 285 communities, sixty were selected for inclusion in the research sample. It was desired to cover as many different combinations of the independent variables as possible, i.e., to select sample communities from as many cells in the matrix as possible. The matrix shown on Table E-1 contains 81 cells, 17 of which are empty, leaving 64 cells or combinations of independent variables available for inclusion in the sample. Of these 64 cells, four were excluded from consideration because they were filled entirely with Puerto Rican communities.[1] Field research staffs were engaged to work in the remaining 60 communities, which composed the sample for the first phase of the field work. Research was completed in 58 of the 60 communities; these 58 localities are indicated in Table E-2.

The frequency distribution shown in Table E-1 and the percentages presented above were derived from the Bureau of the Census Head Start survey information. During the field work it was revealed that a number of these data had to be corrected. City size and ethnicity of clientele (in 1967-1968) were ascertained with a high degree of reliability because these factors are generally known and do not change rapidly. A lesser degree of reliability is associated with delegate agency status because this can and does often change and it was difficult to determine what the status was in each community in the census period. The parent participation data are probably least reliable. It was impossible to verify the reliability of reporting for the time period under question, and the way the census reports are constructed creates a considerable potential for reporting error. Table 1 portrays the corrected data with respect to city size, ethnicity of clientele and delegate agency status and the original parent participation indices of somewhat doubtful reliability.

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[1] American Indian and Puerto Rican communities were eliminated from the sample because of their unique cultural factors and community relationships. It was felt that their inclusion would introduce a series of additional variables that would pose insuperable complications in the analysis, given study resources. Furthermore, research in these communities would have necessitated translating the interview instruments into Spanish or Indian languages, and subsequently separate field testing and revisions. The old "translation-retranslation" method would not have been applicable.

TABLE E-1

NUMERICAL DISTRIBUTION OF 285 COMMUNITIES

ACCORDING TO ALL SAMPLE DESIGN CRITERIA

		Large Cities			Small Cities			Medium-Sized Cities		
		Public School	Trad Agcy	New Agcy	Public School	Trad Agcy	New Agcy	Public School	Trad Agcy	New Agcy
"HIGH" PARTICIPATION	SPANISH	2	0	0	0	3	2	0	0	1
	ANGLO	1	0	1	2	1	13	0	1	4
	NEGRO	0	1	6	1	1	22	2	1	3
"MEDIUM" PARTICIPATION	SPANISH	0	4	0	10	3	11	3	0	1
	ANGLO	0	2	2	17	2	23	3	2	2
	NEGRO	3	3	0	2	4	19	3	1	6
"LOW" PARTICIPATION	SPANISH	4	1	0	5	0	1	0	1	1
	ANGLO	6	0	1	12	1	14	4	1	1
	NEGRO	5	1	1	7	4	9	4	2	5

TABLE E-2

CHARACTERISTICS OF HEAD START COMMUNITIES PHASE I SAMPLE

INITIAL DATA

		"HIGH" PARTICIPATION			"MEDIUM" PARTICIPATION			"LOW" PARTICIPATION			Tot.
		SPANISH	ANGLO	NEGRO	SPANISH	ANGLO	NEGRO	SPANISH	ANGLO	NEGRO	
Large Cities	Public School	Denver, Colo.	Providence, R.I.		Knoxville, Tenn.		Detroit, Mich.	Riverside, Calif.	Portland, Ore.	Compton, Cal. Akron, Ohio Silver Spgs., Md.	9
	Trad. Agency			Yonkers, NY			Chicago, Ill. Milwaukee, Wis.			Washington, D.C.	4
	New Agency		Long Beach, Calif.	Buffalo, N.Y.		Toledo, O			Omaha, Neb.	Baltimore, Md.	5
Small Cities	Public School		Elkhorn Cty, Ky.	Newton, Miss.	Pittsburg, Ks.	E.Las Vegas & W.Las Vegas, N.M.		Perris, Calif.	Marshall, Mo.	Ville Platte, La.	8
	Trad. Agency			Greenwood, Miss.		Springfield, Vermont	Pontotoc, Miss.				3
	New Agency	Poteau, Oka.	Russellville & Ozark, Ark.	Melbourne, Fla. Gainesville, Ga.	Ranchos de Taos, NM	Woodbridge, N.J.	Bentonville, Ark.	Speedwell, Tenn.	Mitchell, S.D.	Tuskegee, Ala.	11
Medium-Sized Cities	Public School			N.Brunswick, N.J.		Newburgh, N.Y.	Lexington, Ky.	Fond du Lac, Wisc.	Beloit, Wisc.	Hamilton, Ohio	6
	Trad. Agency	Galveston, Tex.	Pittsfield, Mass.	Greenville, Miss.		Manchester, Conn.			Kingsport, Tenn.		5
	New Agency	Pueblo, Colo.	Bangor, Me.	Florence, S.C.		Burlington, Iowa	Joliet, Ill.		Provo, Utah	Atlantic Cty, N.J.	7
	TOTALS	4	7	9	3	8	7	4	7	o	58

APPENDIX F

PHASE I FIELD RESEARCH INSTRUMENT

The instrument presented as Exhibit F-1 was divided into a number of sections, each having a specific purpose. (1) The first section was designed to obtain certain background information with respect to the respondents, the community, and local Head Start operations. As previously indicated, one of the reasons for this was to check on the validity of the data provided by the Bureau of the Census in its Head Start survey. (2) The second section, Norms of Change, deals with the respondents' perceptions of change and of Head Start as a change agent. This series of questions was asked of Community Action Agency officials, Head Start officials, and representatives of educational and health institutions. The concern in this section was to obtain information concerning respondent perceptions that could be related to the actual institutional modifications subsequently noted. It is to be emphasized that the focus of this section was not to attempt to assess changes in attitudes but merely to obtain information for possible use in subsequent analyses providing, of course, that systematic relationships were found and that the resources and agency interest were there to perform the necessary analyses. (3) In the third section of the instrument, an attempt was made to obtain information about the nature and extent of efforts to create institutional changes that have involved Head Start staff or parents. Insight was desired about the processes that may have led to change. The information obtained at this time was followed up in the subsequent field work designed to focus on processes and also constituted another set of variables for analytical purposes. (4) The last sections of the instrument dealt with specific changes in school and health institutions relevant to the goals and methods of operation of Head Start.

Three types of interrelated instruments were used during Phase I. One set was administered to CAA and Head Start personnel, another to officials of educational institutions, and a third to officials of health agencies. The instrument presented here is the one that was used in interviewing the first category of respondents (CAA and Head Start personnel). It contains all questions that were included in the school system and health instruments. Many of the questions are the same in all three series, but were organized into three series for ease of administration. The instrument is a long one, but was so designed that if relevant changes did not take place, certain series of questions were not asked and thus the interview time required could be decreased.

EXHIBIT F-1

Interview Schedules
for
OFFICIALS OF THE CAA

HEAD START IMPACT STUDY

Contract No. OEO B 89-4638

Name of Interviewer________________________________

Date of Interview__________________________________

Community____

IV. CHANGES IN THE PUBLIC SCHOOL SYSTEM SINCE 1964 (OR THE YEAR THAT HEAD START BEGAN OPERATING IN THIS COMMUNITY)

HS
DA

22. Does the public school system have paid teachers' aides helping in the classrooms--that is, adults who are not teachers but who are hired to assist teachers?

_____Yes _____No _____Don't know

IF NO: Go to next question.

IF YES:

a. In what year were teachers' aides first employed in the public schools?_________ Don't know________

b. What percent of the public schools employ teachers' aides?_________ Don't know_________

c. Are paid teachers' aides employed primarily in schools in poor neighborhoods?

_____Yes _____No _____Don't know _____Other (what?)_____

____

____

____

d. Are there teachers' aides in all elementary grades or only in some grades?

_____All elementary grades

_____Only some grades (Specify which grades)________________________

____

_____Don't know

e. In total, how many teachers' aides are there in the school system?

________ Don't know________

f. What percent of the teachers' aides who are now employed in the school system come from:

_____High-income backgrounds

_____Middle-income backgrounds

_____Low-income backgrounds

_____Don't know

(Probes continued on next page)

IV. CHANGES IN THE PUBLIC SCHOOL SYSTEM SINCE 1964 (OR THE YEAR THAT HEAD START BEGAN OPERATING IN THIS COMMUNITY) (cont.)

HS
DA

23. I have a card here that lists some possible changes that the local school system might have made in its personnel and staffing arrangements.

a. Would you please read it and tell me, by number, if any of these changes have actually taken place in any elementary schools in the local school system since 1964 (OR THE DATE THAT HEAD START BEGAN IN THIS COMMUNITY)

FOR EACH CHANGE MENTIONED: Circle + (increase) or - (decrease) to indicate the direction of change. If the respondent is uncertain as to whether there was a change or does not know the direction of change, circle the question mark. If the respondent reports "no change", circle the zero.

	Changes	All Schools	Some, but not all Schools	Intended Changes
1. Employment of school nurses	+ - ? 0			
2. Employment of school social workers	+ - ? 0			
3. Employment of dietician	+ - ? 0			
4. Change in the average number of students per teacher	+ - ? 0			
5. Change in the teacher turnover rate	+ - ? 0			
6. Change in the proportion of teachers teaching without a regular license	+ - ? 0			
7. Change in the number of Negro teachers	+ - ? 0			
8. Change in the number of teachers from other minority backgrounds	+ - ? 0			

b. Now would you please look at the card again and tell me for each of the changes you mentioned, whether they have taken place throughout the school system or only in a few schools. (Check column 2 or 3 as appropriate. If unknown, put Unk.)

c. Finally, would you look at the card once again and tell me if any of the items on the list represent intended future changes, say during 1969. (For each item noted as an intended change in 1969, please put a check in column 4. If unknown, put Unk.)

IV. CHANGES IN THE PUBLIC SCHOOL SYSTEM SINCE 1964 (OR THE YEAR THAT HEAD START BEGAN OPERATING IN THE COMMUNITY) (cont.)

24. Here is another card, listing possible changes in curriculum, programs, and facilities. Would you please tell me if any of these have taken place in the local elementary schools since 1964 (or the date that Head Start began in this community).

	Changes	All Schools	Some, but not all Schools	Intended Changes
1. Changes in the teaching of the history and culture of Africa and/or Hispanic America	+ - ? 0	______	______	______
2. Changed emphasis on reading skills	+ - ? 0	______	______	______
3. Changes in Kindergarten curriculum	+ - ? 0	______	______	______
4. Changes in first grade curriculum	+ - ? 0	______	______	______
5. Changes in the quantity of reading materials, audiovisual aids, other teaching aids	+ - ? 0	______	______	______
6. Changes in the physical plant (not classroom space) e.g., playgrounds, recreation areas.	+ - ? 0	______	______	______
7. Changes in classroom space	+ - ? 0	______	______	______
8. Change in the number of hours in the school year	+ - ? 0	______	______	______

a. Now would you please look at the card again and tell me for each of the changes you mentioned, whether they have taken place throughout the school system or only in a few schools. (If unknown, put Unk.)

b. Finally, would you look at the card once again and tell me if any of the items on the list represent intended future change, say during 1969. (If unknown, put Unk.)

FOR EACH ITEM NOTED AS AN INTENDED CHANGE IN 1969, PLEASE PUT A CHECK IN COLUMN HEADED "INTENDED CHANGES."

IV. CHANGES IN THE PUBLIC SCHOOL SYSTEM SINCE 1964 (OR THE YEAR THAT HEAD START BEGAN OPERATING IN THIS COMMUNITY) (cont.)

HS
DA

25. I am now going to mention a number of programs and activities which might be a part of an elementary education program. For each item that I mention, would you indicate whether it is now a part of the local elementary school program or was a part during the last four years (or since the local Head Start program began). If it has been discontinued, please tell me the year it was discontinued.

	Program	Now Part of Program	Was (but not now) Part of Program	Discontinued in what Year?	Available All Schools	Available Some, but not All Schools
1.	Kindergartens	______	______	______	______	______
2.	Pre-Kindergartens	______	______	______	______	______
3.	Project Follow Through	______	______	______	______	______
4.	After-hours Activity Programs	______	______	______	______	______
5.	Tutoring, Homework Help	______	______	______	______	______
6.	Programs for Special Groups, e.g. Migrants, Mentally Retarded	______	______	______	______	______
7.	Provision of Cold Lunches	______	______	______	______	______
8.	Provision of Hot Lunches	______	______	______	______	______
9.	Availability of other food service (breakfast, snacks, etc.)	______	______	______	______	______
10.	Medical Exams	______	______	______	______	______
11.	Dental Exams	______	______	______	______	______

a. For each of the programs and services available in the local elementary schools, would you tell me if they are available in all schools or only some schools.

IV. CHANGES IN THE PUBLIC SCHOOL SYSTEM SINCE 1964 (OR THE YEAR THAT HEAD START BEGAN OPERATING IN THIS COMMUNITY) (cont.)

HS
DA

26. Finally, here is a card listing changes that might have taken place in the relations between schools and parents.

a. Would you please read the card and tell me, by number, if any of these changes have actually taken place in any elementary schools in the local school system since 1964 (OR THE DATE THAT HEAD START BEGAN IN THIS COMMUNITY)

FOR EACH CHANGE MENTIONED: Circle + (increase) or - (decrease) to indicate the direction of change. If the respondent is uncertain as to whether there was a change or does not know the direction of change, circle the question mark. If the respondent reports "no change", circle the zero.

	Changes	All Schools	Some, but not all schools
1. Change in the proportion of parents joining the PTA (or other parent associations)	+ - ? 0	______	______
2. Formation of parents' advisory bodies on school issues	+ - ? 0	______	______
3. Change in the number of parent or neighborhood groups seeking control over the local schools	+ - ? 0	______	______
4. Change in activity of parent and neighborhood groups seeking control over the local schools.	+ - ? 0	______	______
5. Change in the number of parent volunteers helping with school activities.	+ - ? 0	______	______
6. Change in the use of school facilities for after-school activities.	+ - ? 0	______	______

b. Now would you please look at the card again and tell me for each of the changes you mentioned, whether they have taken place throughout the school system or only in a few schools.

V. CHANGES IN HEALTH SERVICES (cont.)

36. I have a card that lists various health services and facilities which might be available in a community. Would you look at this card and tell me which of these services and facilities are available in this community? (Check column 1 if services available. If unknown, put Unk.)

	Services Available	Added Since 1964	Discontinued Since 1964	Change
Facilities				
1. Neighborhood health centers in poor neighborhoods				+ - ? 0
2. Decentralized health facilities				+ - ? 0
3. Mental health centers				+ - ? 0
4. Well-baby clinics				+ - ? 0
5. Dental clinics				+ - ? 0
6.				+ - ? 0
7.				+ - ? 0
8.				+ - ? 0
Services				
1. Medical examinations in public schools				+ - ? 0
2. Dental examinations in public schools				+ - ? 0
3. Referral system among various health agencies				+ - ? 0
4. Coordination of services in various locations				+ - ? 0
5.				+ - ? 0
6.				+ - ? 0
7.				+ - ? 0
8.				+ - ? 0

a. What other services and facilities are available in this community that might be of particular benefit to the poor? (ADD TO LIST)

b. Would you look at the card again and tell me if any of the services now available have been made available since 1964 (or the year that the local Head Start program began)? (Check Column 2 for services added since 1964. If unknown, put Unk.)

c. Have any of the services on the list been discontinued since 1964? (Check Column 3 for services discontinued. If unknown, put Unk.)

d. For each of the items on this list, please describe any changes in the quantity of services or number of facilities that have been available since 1964. (Circle + for increase, - for decrease, ? if change or direction of change is unknown, and 0 for no change.)

V. CHANGES IN HEALTH SERVICES (cont.)

37. Have the poor been involved in any way in the decisions with respect to the changes discussed above; that is, with respect to the addition, deletion or change in the quantity of health services and facilities?

_____Yes _____No _____Don't Know

IF YES: Describe the nature of this involvement? (Probe to determine the relationship, if any, to Head Start.)

38. Are the poor employed in paraprofessional occupations (e.g., medical and dental aides) in any of the community health facilities?

_____Yes _____No _____Don't Know

IF YES:

a. Are they employed in all facilities?

_____Yes _____No _____Don't Know

b. What positions do they occupy?

c. Has the number of paraprofessionals employed in the community health facilities changed since 1964 (or the year the local Head Start program began)?

_____Yes _____No _____Don't Know

IF YES:

a. Describe the changes (absolute number and dispersion throughout the system).

b. What caused the changes? (Probe to determine the relationship, if any, to Head Start.)

APPENDIX G

CHARACTERISTICS OF PHASE I RESPONDENTS

In terms of the total number of Phase I interviews using all three instrument types, approximately 36 percent of the respondents represented public school systems and 35 percent represented the health sectors of their communities (both public and private health). The remaining 29 percent of the respondents consisted of individuals associated with Head Start programs, CAA's, and Head Start delegate agencies.

Table G-1 presents the frequencies of respondent characteristics according to type of questionnaire administered. By far the greatest majority of respondents were Anglo male; 65 percent of the respondents representing both schools and health institutions had these characteristics. The second highest category was that of Anglo females, but they ranked far lower in number than Anglo males in health institutions and schools. But, among Head Start, CAA, and delegate agency personnel, there is a more even distribution of respondents with respect to race and sex. There were significantly higher proportions of blacks (both male and female) and Anglo women represented here than there were among school system and health agency respondents.

Respondents representing Head Start and CAA also tended to be younger than those in schools and health institutions. A majority (55 percent) of the Head Start and CAA respondents were forty years of age or younger; only three percent were over fifty. In contrast, only 21 percent of the respondents in the health sector were forty or under, and an even smaller proportion of the school system respondents (ten percent) were in this age group. Almost half (48 percent) of the school system respondents were over fifty years of age; 38 percent of the health-sector respondents fell into this age group.

Most CAA and Head Start respondents had less tenure in their positions than respondents from schools and health institutions. Eighty-four percent of CAA and Head Start respondents had less than three years experience in their jobs. On the other hand, about half the respondents in the educational and health institutions had been in their positions for at least four years--many for more than ten years.

TABLE G-1

Characteristics of Phase I Respondents

Title	*Percent of Total Respondents Interviewed with CAA Questionnaire	Ethnicity and Sex	%*	Age	%*	Years in Present Position	%*
CAA Director	34	Negro Female	14	20-30 years	11	Less than 6 mos.	12
Head Start Director	25	Negro Male	16	31-40 years	44	6 mos. to 3 yrs.	72
Delegate Agency Director	21	White Female	33	41-50 years	35	4 yrs. or more	12
Other CAA Staff Personnel	20	White Male	18	51-60 years	3	Info. not given	4
		Spanish-American Male	2	Info. not given	7		
		Oriental Female	1				
		Info. not given	16				

TABLE G-1 (Continued)

Title	*PERCENT OF TOTAL RESPONDENTS INTERVIEWED WITH HEALTH QUESTIONNAIRE	Ethnicity and Sex	%*	Age	%*	YEARS IN PRESENT POSITION	%*
Public Health Director	33	Negro Female	2	20-30 years	3	Less than 6 mos.	4
Director of Maternal and Child Health	18	Negro Male	3	31-40 years	21	6 mos. to 3 yrs.	45
Medical Association Representative	24	White Female	25	41-50 years	26	4 to 10 yrs.	24
Dental Association Representative	18	White Male	65	51-60 years	26	11 yrs. or more	23
School Nurse	5	Spanish-American Female	2			Info. not given	4
Other CAA Personnel	2			61-70 years	12		
		Info. not given	3	Info. not given	12		

TABLE G-1 (Continued)

TITLE	*PERCENT OF TOTAL RESPONDENTS INTERVIEWED WITH SCHOOL QUESTIONNAIRE	ETHNICITY AND SEX	%*	AGE	%*	YEARS IN PRESENT POSITION	%*
School Board President and Member	25	Negro Female	4	20-30 years	1	Less than 6 mos.	8
School Superintendent	25	Negro Male	9	31-40 years	10	6 mos. to 3 yrs	42
Principal	30	White Female	18	41-50 years	40	4-10 yrs.	33
Other School Administrative Staff Personnel	12	White Male	65	51-60 years	40	11 yrs. or more	15
Head Start Director	5	Spanish-American Male	2	61-70 years	8	Info. not given	2
Public School Teacher	3	Info. not given	2	Info. not given	1		

APPENDIX H

PROCEDURES UTILIZED IN AN ANALYSIS OF INDEPENDENT AND DEPENDENT VARIABLES

The 58 communities included in the Phase I sample were selected on the basis of (1) the presence of a local year-round Head Start program and (2) the presence of a poverty population in the community. In addition, four hypothetical independent variables were selected for initial consideration, and the 58 sample communities were chosen to represent a variety of combinations of these variables. The four independent variables hypothesized to have a relationship to change were:

1. City size
2. Level of parent participation in the Head Start program
3. Major ethnic group served by Head Start
4. Type of delegate agency operating Head Start

From the results of interviews conducted during Phase I, five dependent variable areas emerged. These variables are:

1. Changes in parental involvement in schools
2. Changes in minority group rights
3. Changes in health and social service
4. Changes in educational programs and curricula
5. Changes in physical plants of educational institutions

The five dependent variable areas were cross-tabulated with the four independent variables. This analysis was designed to illuminate possible factors concomitant with institutional changes rather than to provide indications of the change origins or the processes of change. Chi square was utilized as a suggestive statistical indicator of relative importance of the interaction observed. Where the value of p is equal to or less than .100, interactions were given closest scrutiny. Specific questions and subquestions were selected from the Phase I questionnaires to serve as prime indicators of institutional change. They were precoded so that four types of response possibilities were available: i.e., desirable change (+), undesirable or negative change (-), unknown, (?), or absence of change (∅). Responses to these questions and subquestions were cross-tabulated with the four independent variables.

For purposes of this analysis, a desirable change was one consistent with Head Start goals and policies such as an increase in employment of poverty neighborhood residents by a local school system in paraprofessional positions.

Interview data were double-coded, punched and verified, and then processed by computer for a variety of analyses. The principal purpose was to examine the degree to which systematic relationships between the independent and dependent variables existed. Another purpose was to analyze the data to elicit suggestive conclusions for later examination. Because of the quantity of data collected during more than 500 interviews, the processing could be accomplished economically only by computer (IBM 360-40). Results of these analyses will be made available on request.

APPENDIX I

PHASE I QUESTIONNAIRE ITEMS BY CATEGORY

1. Increased involvement of the poor with institutions, particularly at decision-making levels and in decision-making capacities.

--Change in the proportion of parents joining the PTA (or other parent associations).

--Formation of parents' advisory bodies on school issues.

--Change in the number of parent or neighborhood groups seeking control over the local schools.

--Change in activity of parent and neighborhood groups seeking control over the local schools.

--Change in the number of parent volunteers helping with school activities.

--Change in the use of school facilities for after-school activities.

--Involvement of the poor in recent decisions pertaining to changes in health services.

2. Greater employment of local persons in paraprofessional educational occupations.

--Employment of teacher aides in the public school system.

3. Greater educational emphasis on the particular needs of the poor and minorities.

--Employment of school social workers.

--Change in average number of students per teacher.

--Change in the teacher turnover rate.

--Change in the proportion of teachers teaching without a regular license.

--Change in the number of Negro teachers.

--Change in the number of teachers from other minority backgrounds.

--Changes in the teaching of the history and culture of Africa and/or Hispanic America.

--Changed emphasis on reading skills.

--Changes in kindergarten curriculum (additional courses).

--Changes in first grade curriculum (additional courses).

--Changes in the quantity of reading materials, audiovisual aids, other teaching aids.

--Changes in the physical plant (not classroom space) e.g., playgrounds, recreation areas.

--Changes in classroom space.

--Changes in the number of hours in the school year.

--Kindergartens.

--Prekindergartens.

--Project Follow Through.

--After-hours activity programs.

--Tutoring, homework help.

--Programs for special groups, e.g., migrants, mentally retarded.

--Provision of cold lunches.

--Provision of hot lunches.

--Availability of other food service (breakfast, snacks, etc.).

4. Modification of health services and practices to serve the poor more effectively.

--Neighborhood health centers in poor neighborhoods.

--Decentralized health facilities.

--Mental health centers.

--Well-baby clinics.

--Dental clinics.

--Employment of school nurses.

--Employment of dieticians.

--Medical examinations in public schools.

--Dental examinations in public schools.

--Referral system among various health agencies.

--Coordination of services in various locations.

APPENDIX J

SELECTION OF PHASE II COMMUNITIES AND CHANGES

During the analysis of the Phase I results, certain questionnaire items were selected for use as indicators of change; these included primarily some of the questions included in the final sections of the interview instrument: "Changes in Health Services" and "Changes in School Systems," and selected questions from the "Efforts Toward Change" sections. On the basis of responses to these items, communities included in the first phase survey were classified as either high-, medium-, or low-impact communities. Assignment of each community to one of these three impact categories was made by cumulating responses for each community and arranging these totals (one per community) in rank order. The total range of impact totals was then trisected; communities falling into the upper third of the distribution (11) were considered high-impact localities; those in the lower third (12), low-impact localities; the remainder--in the midsection--were classed as medium-impact communities.

Positive and negative impacts (in respect to achieving Head Start goals) were cumulated separately. In those few cases where positive impact results were complicated by high levels of negative impacts, the community was marked down into the next lower impact category. Generally, the frequency of negative impacts within communities was so low and the distribution of negative impacts so sparse that it was not felt necessary to establish a separate negative impact category. Thus, all first-wave communities were classified into the three positive change categories cited.

Since positive change was so pervasive, it was necessary to eliminate some communities from the second phase sample so that project resources could be concentrated on intensive studies of change in a smaller sample of communities rather than on a superficial study of all changes in all 58 communities. If all changes in all communities had been included, it would not have been possible to study impact development in even minimal depth and detail.

Initially it was decided to examine only the high- and low-impact communities, so that the opportunities for comparing these two types of situations could be maximized. It was desired to examine the development of changes in both high- and low-impact communities, to compare resulting data from communities reflecting both impact types, and, if possible, to isolate the operation of the same factors but at different levels for each of the impact categories. Consequently, all high- and low-impact communities were included in the Phase II sample. Subsequently a majority of the medium-impact communities, 21 of the 35, were also included during the second wave at the request of the Head Start Project Officer. The remaining 14 medium-impact communities were eliminated. Thus, a total of 42 communities was included in the second wave sample. The method of selection of these communities gives no reason to believe that there is a bias that would influence the results of the field work. Table J-1 lists these communities and the major independent variables. Table J-2 shows the distribution of change areas assigned for research during Phase II.

TABLE J-1

PHASE II COMMUNITIES AND THEIR CHARACTERISTICS

Impact Rank	Name of Second-Wave Communities	City Size	Delegate Agency	Parent Participation	Clientele Ethnicity
	Tuskegee, Ala.	Small	Public School	Low	Negro
	Compton, Cal.	Large	Public School	Low	Negro
H	Elkhorn City, Ky.	Small	Public School	High	Anglo
	Lexington, Ky.	Medium	Public School	Medium	Negro
I	Detroit, Mich.	Large	Public School	Medium	Negro
	Omaha, Neb.	Large	Public School	Low	Negro
G	W.Las Vegas, N.M.	Small	Public School	Medium	Span-Am.
	Poteau, Okla.	Small	New	High	Span-Am.
H	Providence, R.I.	Large	Public School	High	Anglo
	Milwaukee, Wis.	Large	New	Medium	Negro
	Total 10 Communities				
	Long Beach, Cal.	Large	Mixed	High	Negro
M	Perris, Cal.	Small	Public School	Low	Span-Am.
	Riverside, Cal.	Large	Mixed	Low	Span-Am.
E	Denver, Colo.	Large	Mixed	High	Span-Am.
	Gainesville, Ga.	Small	New	High	Negro
D	Chicago, Ill.	Large	Mixed	Medium	Negro
	Joliet, Ill.	Medium	New	Medium	Negro
I	Burlington, Iowa	Medium	New	Medium	Anglo
	Ville Platte, La.	Small	New	Low	Negro
U	Atlantic City, N. J.	Medium	New	Low	Negro
	Woodbridge, N.J.	Small	New	Medium	Anglo
M	E.Las Vegas, N.M.	Small	Public School	Medium	Span-Am.
	Portland, Ore.	Large	Public School	Low	Negro

TABLE J-1 (Continued)

Impact Rank	Name of Second-Wave Communities	City Size	Delegate Agency	Parent Partici-pation	Clientele Ethnicity
M	Buffalo, N. Y.	Large	Traditional	High	Negro
E	Newburgh, N. Y.	Medium	Public School	Medium	Negro
D	Akron, Ohio	Large	Public School	Low	Negro
I	Florence, S.C.	Medium	New	High	Negro
U	Knoxville, Tenn.	Large	Public School	Medium	Anglo
M	Provo, Utah	Medium	Public School	Low	Anglo
	Fond du Lac, Wis.	Medium	New	Low	Anglo
	Total 20 Communities				
	Pueblo, Colo.	Medium	New	High	Span-Am.
	Pittsburgh, Kans.	Small	New	Medium	Anglo
	Bangor, Maine	Medium	Mixed	High	Anglo
L	Greenville, Miss.	Medium	New	High	Negro
	Greenwood, Miss.	Small	Traditional	High	Negro
O	Newton, Miss.	Small	Public School	High	Negro
	Marshall, Mo.	Small	New	Low	Anglo
W	Hamilton, Ohio	Medium	Public School	Low	Negro
	Mitchell, S.D.	Small	New	Low	Anglo
	Kingsport, Tenn.	Medium	New	Low	Anglo
	Speedwell, Tenn.	Small	New	Low	Anglo
	Galveston, Tex.	Medium	Traditional	High	Negro
	Total 12 Communities				
	Total 42 Communities				

TABLE J-2

NATURE AND DISTRIBUTION OF THE TYPES OF CHANGES ASSIGNED FOR INVESTIGATION DURING PHASE II INTERVIEWS

TYPES OF CHANGES (IMPACTS)	DISTRIBUTION					
	High & Medium Impact Communities		Low Impact Communities		Totals	
	Primary*	Secondary*	Primary*	Secondary*	Primary*	Secondary*
1. Increase (or decrease) in health services available to the poor (CAA Q 36d; H Q 23d)	9	8	4	7	13	15
2. Changes in school curriculum, programs, and facilities reflecting increased (or decreased) concern with early childhood education and the primary grades (CAA Q 24a; S Q 23a)	7	5	0	3	7	8
3. Employment of teacher aides or changes (increase or decrease) in number since HS (CAA Q 22b; S Q 20b)	6	8	3	0	9	8
4. Changes in school curricula, services, and personnel reflecting increased (or decreased) concern for educational needs of deprived and minority-group children (CAA Q 23a; S Q 21a)	4	5	4	1	8	6
5. Increased (or decreased) involvement of poor in decisions or changes in public schools (CAA Q 16e & 26; S Q 16e & 26)	3	1	1	0	4	1
6. Increased (or decreased) involvement of the poor in decisions or changes in health facilities & services available to poor (CAA Q 37; H Q 24)	1	2	0	1	1	3
TOTALS	30	29**	12	12	42	41**

*Primary and Secondary Impacts selected for each community were based on the community changes identified from analysis of Phase I findings. "Primary Impacts" are defined as specified institutional changes assigned to field research associates for intensive study during Phase II. Institutional changes noted as "Secondary Impacts" were to be studied only in the event that research of the Primary Impact was found to be infeasible.

**In one community, no secondary impact was assigned because of prior assurances by the field research associate that the primary impact was appropriate.

TABLE J-2 (Continued)

NATURE AND DISTRIBUTION OF CHANGES ON WHICH
PHASE II INVESTIGATIONS WERE COMPLETED

TYPES OF CHANGES (IMPACTS)	DISTRIBUTION						
	High & Medium Impact Communities			Low Impact Communities			Totals
	Primary	Secondary	Other*	Primary	Secondary	Other*	
1. Increase (or decrease) in health services available to the poor.	8	1	0	4	1	0	14
2. Changes in school curriculum programs and facilities reflecting increased (or decreased) concern with early childhood education and the primary grades.	3	2	0	0	0	1	6
3. Employment of teacher aides or changes (increase or decrease) in number since HS.	5	2	2	3	0	0	12
4. Changes in school curricula, services, and personnel reflecting increased (or decreased) concern for educational needs of deprived and minority-group children.	4	1	1	2	0	0	8
5. Increased (or decreased) involvement of poor in decisions or changes in public schools.	3	1	0	1	0	1	6
6. Increased (or decreased) involvement of the poor in decisions or changes in health facilities & services available to poor.	1	0	0	0	0	0	1
TOTALS	24	7	3	10	1	2	47

*In five communities, neither the Primary nor the Secondary Impacts assigned were appropriate to the local situations; consequently, in these five communities a third ("other") impact category was assigned for investigation.

APPENDIX K

PHASE II INSTRUMENTS

EXHIBIT K-1:	GUIDE TO FIELD WORK PHASE II
EXHIBIT K-2:	FORM A, ASSIGNMENT OF PRIMARY AND SECONDARY IMPACT AREAS
EXHIBIT K-3:	FORM B, INTERVIEW GUIDE AND REPORTING FORM
EXHIBIT K-4:	FORM D, SUMMARY SHEETS AND INSTRUCTIONS FOR FINAL NARRATIVE REPORTS

EXHIBIT K-1

GUIDE TO FIELD WORK - PHASE II

April 1969

NATURE OF PROJECT

Head Start is one of the most pervasive of all OEO programs. Much research has been done and is being undertaken to determine the impacts of this program on the youngsters whom it has served, as well as their parents and others directly involved in the program. The present research, on the other hand, focuses explicitly on the effects that Head Start has had on community organizations and institutions and not on the consequences of the program on children and their families. The principal objectives of this project may be stated as follows: (1) to identify and define relevant institutional changes and impacts that have been effected in particular community organizations; and (2) to trace out the carriers and agents for the changes that have been identified, as well as to probe for reasons behind the changes to determine the ways in which Head Start was involved.

The significance of this research centers on methods of achieving institutional change in local settings. To the extent that this inquiry sheds light on this subject, it permits the design of Head Start to be more effective. Also, it is hoped that from this research other strategies for increasing the responsiveness of local organizations to the needs of the poor will be developed or enhanced.

RESEARCH DESIGN

The design governing the conduct of the research has divided the investigation into two phases. Initially, during Phase I, information pertaining to changes in community educational and health institutions was elicited from specified respondents in a sample of communities. These data were subsquently analyzed, and selected changes from each community have been identified for further investigation during Phase II of the research.

The purpose of Phase II is to determine how these selected changes were brought about. More specifically, for each of the institutional changes identified for investigation in Phase II it will be necessary to determine:

1. How the change was initiated
2. The exact nature and magnitude of the change
3. Who or what organizations were involved in effecting the change
4. Who were the advocates and opponents of the change
5. What are the implications of the change for the poor and for the institution which made the change
6. What was the contribution or role (if any) of Head Start in effecting the change

Clearly, in any community, Head Start will not be the only active element generating or implementing new ideas. Individuals and groups at federal, state, and local levels have been working to achieve various changes during this period, and many of the changes assigned for investigation during Phase II will indoubtedly be the result of multiple causes. What we want to know as a result of your investigation is what were the carriers and agents for a particular change and whether or not Head Start was among them. You are also asked to assess the relative importance of Head Start's influence vis-a-vis other causal agents in the decision to effect change.

Phase II of the research will be accomplished using a variety of data collection techniques. We will provide you with general guidelines upon which to pattern your activities. However, because of the variety of reported changes, sources of information, and the diverse circumstances surrounding the development of change from community to community, we have designed a relatively unstructured guide to direct your research. This guide and the research you conduct rely heavily upon your own knowledge, ingenuity, and expertise.

This investigation will require interviewing persons in the CAA, the schools, and health institutions. In addition, it will also be necessary to interview people outside of the above institutions to corroborate your findings and to provide necessary objectivity to your reporting. It must be emphasized that to the extent possible, your research during this period should seek factual data and not personal opinion.

Drawing upon the results of your research, we will try to provide an understanding of the inputs, processes, and outcomes of change. Our success will clearly depend in very large measure on your insights, tenacity, thoroughness, and awareness of local conditions that you bring to this research effort.

DEFINITION OF TERMS

Impact and Change

It is essential for each research associate to understand what is meant by "Head Start influence," "Head Start impact," "change related to Head Start," and similar wordings of the same concept. These terms are used to indicate that Head Start, by virtue of its activities or merely its existence, has in some way affected decisions to make change. In this regard, it is not necessary that Head Start's influence was intentional or direct. Moreover, it is not necessary that Head Start tried to exert influence. If Head Start showed by its example, for instance, that nonprofessional aides provide competent service, and if a health clinic decided to use aides partly because of the persuasion of the Head Start example, that is a sufficient "relationship to Head Start."

An impact or change, of course, can be either negative or positive: positive, for example, by helping to improve conditions and the quality of life among the poor. A negative impact, on the other hand, might be exemplified by the reduction or elimination of a clinic or kindergarten program.

Head Start

We are interpreting the term Head Start broadly to include the local Head Start program offering health or educational services, its staff members (professional and nonprofessional), the parents' advisory board, and parents of children in the Head Start classes. Also included in our definition of Head Start is the general concept of Head Start whether or not a local Head Start center was present or active in effecting change. In other words, geographic locus is not an essential element of Head Start in the sense of its having effects. For example, a change could result without any activity on the part of a local, regional, or national Head Start office; i.e., the very concepts of Head Start could be the cause of an institutional change.

STATEMENT OF WORK

The research to be undertaken for this phase of the Head Start Impacts study involves the fulfillment of the following tasks:

1. Interviewing respondents and, where necessary, researching records and documents to determine how a specified institutional change was effected in community institutions. (You should resort to detailed examination and analysis of written records and documents only if you cannot obtain valid information from the persons you interview.)

2. Reporting to Kirschner Associates, Inc. (KAI) the results of all interviews and investigations relevant to the study.

3. Preparing a final narrative report which presents the data obtained during the research and provides, in addition, the views and insights of the field research associate.

The procedures for accomplishing the objectives noted are described in detail below.

PROCEDURES

Review of Phase I Materials

Each research associate has been assigned to research a specified institutional change, selected on the basis of an analysis of the Phase I interview responses obtained in his community. The institutional change assigned for research in your community is described in Form A.

Using this list of changes as a guide, you should review each of the Phase I interviews to identify all persons who have previously made reference to the change identified on Form A for additional investigation. This review will serve the purpose of refreshing your memory about information provided previously as well as offering any leads that may have been offered regarding follow-up inquiries that might be conducted. In addition, this review will provide you with information which can be used in your final narrative report. It should be emphasized that this review of the Phase I interviews is an essential activity which must be accomplished before conducting any Phase II interviews. Respondents should not be asked to duplicate information that has been provided previously and recorded on Phase I interview schedules.

Persons to be Interviewed

Once you have reviewed all the Phase I interview schedules, you must determine who or what sources of data could provide relevant information about the specified institutional change. (Form B contains a complete list of the information required.) In your detailed investigation of the change or impact, it is essential that the Head Start Director be reinterviewed. For our analysis, it is particularly important to have the Head Start Director's perceptions of the change we have selected for detailed investigation, including: (1) whether or not he views the changes as an impact of Head Start; and (2) the role of Head Start (if any, in effecting the change. In addition, the Head Start Director will probably be able to direct you to other individuals, organizations, and relevant data sources.

Undoubtedly, some of the other persons interviewed during Phase I will be reinterviewed during Phase II. Informants from the first-phase interviews selected for reinterviews will include, among others:

Former Head Start Directors
Directors of agencies sponsoring Head Start (Delegate agencies)
CAA Directors
Former CAA Directors
Superintendents of Schools
Chairmen of School Boards
Principals of Head Start-neighborhood schools
Head of the city or county health departments
Head of other health agencies concerned with the poor
Directors of clinics, hospitals, health centers, private health agencies, etc.
Local physicians and dentists
Representatives of medical and dental professional organizations

It is anticipated that those persons who appeared most knowledgeable about each change will be contacted for additional information. However, making contacts with respondents previously interviewed will represent only a starting point for your subsequent investigation. You should elicit from each person you contact the names of other persons and organizations that were involved in each aspect of the change or who would be knowledgeable about the change being investigated. Additional informants during Phase II might be:

Newspaper editors and reporters

Clergy

Officials and members of civic organizations involved with the poor

In all cases, we are relying upon you to select those respondents and informational sources that you feel will be most productive in providing you with the necessary data.

Interviews

As indicated earlier, a highly structured type of interview is not planned. Utilizing the questions contined in Form B as a guide, you should formulate your own questions which will elicit data which are responsive to the topics covered in Form B and which will fully illuminate the change being investigated. In all cases, you should build upon the data already in your possession from the Phase I inquiry.

During each interview, you may use Form B or Form C to insure that you have covered all topics of relevance. On the basis of the pre-test of these instruments, most interviewers reported that their interviews did not proceed exactly in the order that the items are specified in Form B. For this reason, they found the checklist (Form C) to be more useful than Form B as an interview guide. Remember, you are to supplement the items in Form B or Form C (whichever you use) with your own questions and probes.

Obviously, much of the information about any one change is a matter of each respondent's interpretations of circumstances and issues rather than hard, objective fact. It is up to you to explore varied viewpoints fully by seeking corroboration from as many sources as you deem appropriate and, if necessary, by relating discrepant viewpoints to other respondents to obtain from them their views of the issue. This may require return visits or telephone calls to respondents already interviewed. You are encouraged to pursue the circumstances surrounding each specified change until the issue becomes clear or it is clearly unresolvable.

When discrepancies arise during your investigation, you should focus on the facts of the situation. When was the decision made to implement a change? When did the educational or health agency begin consideration of the change? What did the presumptive causal factors (either personal or impersonal forces) do that was visible to the institution's decision makers? At what points in time did such activities occur? If some fact in dispute is critical to an understanding of the situation you are investigating, we urge you to search relevant records and documents to insure that you have a reliable account of the situation.

For each interview that is conducted, a copy of Form B must be filled out completely. If a respondent is unable to respond to any portion of the interview guide (Form B), please note this on the form and give the reasons why the respondent could not provide the data. Do not leave any of the topics covered in Form B blank without an explanation for the omission.

If it becomes obvious that a respondent is unfamiliar with the change you are investigating, note this fact and terminate the interview. Make sure, however, that the respondent has been given a complete description of the institutional change in question and that you explore leads to other sources of information with him.

Some informants will probably make courtesy references to Head Start's influence since this is known as a Head Start study and they are aware of the interest that Head Start must have in the research. Do not accept such gestures of politeness as an indication of Head Start's influence without exploring them further to determine their substance. Always probe deeply for how a presumed causal factor is related to the change, the period of time, who was involved, etc. We require valid reports of the sources and causes of change. Candor and accuracy are much more important than inflated, unreliable reporting. Again, do not hesitate to challenge your respondents politely or to ask for corroborative details. At times it may be best to let a dubious statement go and to come back to it later in the interview, perhaps when another related point is raised; this is, of course, up to the interviewer and his sense of timing.

It is necessary that at least three interviews be conducted with informed respondents during Phase II. Although it is probable that more than three interviews will be required to obtain all information requested, it is, of course, impossible for us to specify precisely the number of required interviews. For this reason, we ask that you budget your time so that you are able to conduct sufficient interviews to provide the desired information. This will necessitate planning a strategy to research the assigned impact.

The emphasis on interviews is not to be construed as limiting your activities solely to interviewing. If you are unable to obtain reliable data from your respondents, a portion of your time may be spent in examining documents, records, minutes of meetings, newspaper articles, etc. Whenever possible, please provide us with copies, excerpts, or abstracts which you feel are relevant to this research.

(Please note: You have been provided with four copies each of the Forms B and C. Please retain one blank copy of each from which to make additional copies for your use.)

REPORTING

Weekly Reports

During the course of this project, we expect you to submit weekly reports containing the following forms and information:

1. Copies of Form B that were completed during the week;
2. A list of persons interviewed during the week, giving name, position, and telephone number of each;
3. A schedule of your research activities for the following week.

By collecting information throughout the course of the research, we will be able to begin our analysis immediately and make necessary corrections in the light of any weaknesses revealed.

Be sure to retain a Xerox copy of all Form B's submitted to the central office. These schedules will contain information which you will need to prepare your final narrative report.

Final Narrative Reports

It will be necessary for you to prepare a final narrative report containing the information you have accumulated during the interviews and your examination of documents and records. This report should detail the major causes of the change being investigated, how and in what sequence the change developed, what organizations and individuals were involved, how the change was implemented, and the time period which elapsed from initiation of the concept for the change to the date of implementation. Pay particular note to the sequence in which events took place and the time lapse between the more important events, such as initiation of the change concept, discussions about whether or not to make the change, and the final decision to make the change. It is also important that you describe any conflicts and their resolution during the development of each change.

The final narrative report for the assigned change should draw upon all of your sources of information. If different informants have provided you with contradictory information or divergent views regarding the same circumstances, be sure to describe the various viewpoints and explain in your narrative why you accept one interpretation rather than others. Also, be sure to document your statements and indicate where you are offering your own perceptions and viewpoints. This report must cover all of the topics listed in Form B although it need not adhere to the style or format of Form B.

We expect that your final narrative report on the institutional change will be reasonably brief but adequately buttressed with data and specific illustrations so that others can make their own appraisal and judgments from the materials you have provided. These reports should be typewritten but it is not essential or required that they be submitted in manuscript or finished form.

A copy of Form D should accompany the final narrative report. This form has been designed to provide us with a summary list of persons interviewed and other data sources. In addition, this form provides space for you to describe the change you have been investigating. Although each research associate has been given a comprehensive change to investigate during this phase of the research, in many cases it has not been possible, on the basis of Phase I information, for us to identify precisely all aspects of the change. For example, an assigned change for investigation might be "decentralized health facilities." Quite clearly this may involve a variety of changes which were not stated explicitly in the Phase I interview reports, such as the addition of new buildings, hiring of indigenous personnel, the use of paraprofessionals, extended office hours, etc. It is therefore necessary for you to provide us with an abstract which describes, to the best of your knowledge, the institutional change you have investigated.

You should submit to the central office your final narrative report, all interview notes, and copies of documents and records no later than May 26.

EXHIBIT K-2

FORM A

ASSIGNMENT OF PRIMARY AND SECONDARY IMPACT AREAS

The institutional change selected for intensive investigation in your community is described on the following page. This change, designated as the "Primary Impact," should be the focus of your investigation during Phase II of the Head Start Impacts study. A Secondary Impact has been assigned as a substitute in the event that research on the Primary Impact is not feasible. Only if the following conditions exist should you focus on the Secondary Impact.

(1) Your initial interviews reveal that the Primary Impact did not in fact take place (i.e., change has not occurred),

or

(2) You are unable to contact anyone with knowledge of the sources and causes of change (e.g., all individuals having knowledge of the change have left town).

You will note that the "Impacts" selected for study have been described here in very generalized terms and may in fact be comprised of as many as eight or nine other distinct changes. For example, an impact may be stated as an "Increase in health services available to the poor." This comprehensive impact may encompass such specific changes as the opening of neighborhood health centers, mental health centers, well-baby clinics, and a variety of other new facilities. Each of these specific changes may in turn encompass a wide range of more subtle changes, such as the hiring of new personnel to staff the facilities, changes in institutional policies to meet the needs or demands of citizens in poor neighborhoods, etc. You do not have sufficient time to explore in depth all facets of the Primary or the Secondary Impact. Therefore, it will be necessary for you to concentrate on a few specific changes which exemplify the Primary (or Secondary) Impact. These changes should be those which appear most productive in terms of availability of data and their relationship to Head Start.

To determine which specific changes would be most valuable to research, you should begin your study on a generalized level, conducting approximately two or three interviews with Phase I respondents who are knowledgeable about the assigned impact. (These persons will be identified from your review of the Phase I interviews.)

Following these initial interviews, you should be able to identify one or two specific changes to investigate in depth. The changes you finally select for intensive study will be those which appear most productive in terms of their relationship to Head Start and availability of data.

Please telephone the central office after you have selected the specific changes for in-depth investigation so that we may confirm your selection.

EXHIBIT K-3

HEAD START IMPACT STUDY - PHASE II

FORM B

INTERVIEW GUIDE & REPORTING FORM

INSTRUCTIONS

This guide was designed to focus your attention on specific areas of interest and is intended for use during each interview as a reminder to cover all areas cited. Under the several general topic headings, a number of suggested probes and questions are provided for use during your interviews. These probes and questions define the dimensions of our interests and should not be construed as a limit to the scope of your investigation. Remember, you are expected to develop your own questions for probing more deeply into these subject areas. We are relying on you to utilize your skills for determining how to direct your respondents to focus only on issues and statements of importance and not digress into areas not vital to the institutional change being researched.

We expect your interviews to proceed in a conversational manner. The points in this guide need not be discussed in the order presented unless, in your judgment, it suits the nature of the interview.

You should record your interview proceedings on these pages. Please record your questions and probes as well as all responses you obtain.

At the outset of each interview, please make sure to obtain from your respondent the information requested on page 2 of this form. Upon completion of your interview, please fill out the form on page 12.

NOTE: You may use either Form B or Form C as an interview guide. A copy of Form B must be completed for each interview you conduct. Completed Form B's should accompany your weekly report to the central office. In preparing Form B, you may use item 12 to discuss topics not covered elsewhere in the schedule. Please add additional pages to this schedule if necessary.

For Office
Use Only

Appendix K

KIRSCHNER ASSOCIATES, INC.

HEAD START IMPACT STUDY - PHASE II

FORM B

1.
Date(s) of Interview____________________
Target Community____________________

2.
Name of Respondent____________________
Exact Title____________________
Organization____________________
Office Telephone____________________
Sex________ Ethnicity________ Approximate Age________
Years in Present Position ____________________
Interviewed for Phase I? Yes_____ No_____ Don't Know_____

3.
Name of Interviewer____________________
Sex________ Ethnicity________ Age________

4.
Description of Institutional Change____________________
____
____
____

IMPORTANT: Please fill in all items on this sheet for each interview conducted.

For Office
Use Only

Form B (Continued)

5. REASONS FOR CHANGE

What were the circumstances which provided an environment for change? What were the circumstances leading up to this change? What specific events, institutional arrangements, political considerations, personalities, etc., were instrumental in providing an environment for this change?

Did the Head Start program or any aspect of Head Start have an influence on the environment which produced this change?

For Office Use Only

Form B (Continued)

6. ORIGINS OF CHANGE

Who or what institutions were responsible for initiating the concept of this change? When was change first suggested?

Can stages of development of this change be clearly defined? If so, identify individuals and organizations playing major roles at each stage. Trace out events, decisions.

Describe the role of Head Start (if any) in generating this change.

For Office Use Only

Form B (Continued)

7. ADVOCATES AND SUPPORTERS OF THE CHANGE

Identify the advocates and supporters of the change. Give names of persons and organizations and positions of individuals who were advocates of the change. Provide information on their relevant characteristics (e.g., race, organizational affiliations, experience, and activities, etc.) which might indicate why they had an interest in this issue.

How did these advocates go about encouraging the institution to make the change? What techniques and methods did they use?

In what ways did Head Start play a role in advocating or supporting this change?

For Office
Use Only

Form B (Continued)

8. OPPONENTS OF THE CHANGE

Identify the opponents of this change. Give names of persons and organizations and positions of individuals who provide resistance to the change. Provide information on relevant characteristics of these opponents (e.g., race, organizational affiliations, experience and activities, etc.) which might indicate why they had an interest in this issue.

How did the opponents of this change go about discouraging the institution to make the change? What methods and techniques did they use?

What role did Head Start play with respect to opposition to the change? If Head Start opposed the change, describe the nature of its activities to discourage this change. If Head Start advocated change, describe how it worked to eliminate opposition to the change.

For Office
Use Only

Form B (Continued)

9. IMPLEMENTATION OF CHANGE

Describe procedures and indicate persons involved with authorization of change. Describe Head Start's role (if any).

What was the source of funding which made it possible to implement this change? Describe the financial implications of the change.

For Office Use Only

Form B (Continued)

10. MAGNITUDE AND ASSESSMENT OF CHANGE

What is the extent of the change? How many and what kinds of units of the institution have been affected? (How many schools, clinics, etc., have made the change?) How large a geographic area is affected? Approximately how many clients (i.e., students or patients) are affected by this change?

To what extent did this change mark a departure from previous policies or practices of the institution?

Describe the extent to which the change has been implemented in accordance with the initial concept for the change. Describe any compromises the advocates for change had to make because of resistance or lack of funds.

What impact did this change have on the lives of the poor? (Describe impact on poor and indicate whether it is favorable or unfavorable.)

For Office
Use Only

Form B (Continued)

11. ROLE OF RESPONDENT AND HIS ORGANIZATION IN THE CHANGE

What was the respondent's role in the initiation or development of the change? Was he in favor of or opposed to the change? What was the role of his organization? Describe the impact of this change on the respondent's organization (i.e., modified institutional structure, altered goals of other agency programs, etc.).

For Office Use
Only

Form B (Continued)

Appendix K

12. OTHER RELEVANT INFORMATION

For Office Use
Only

Form B (Continued)

13. REFERENCE TO OTHER SOURCES OF INFORMATION

Ask respondent to direct you to other individuals who are knowledgeable about the development of this change. Ask him also to suggest appropriate records containing relevant information.

For Office Use Onl

Form B (Continued)

NOTE: Items 14 - 18 should be completed following each interview. If you have completed these items on Form C, you may discard this page and attach page 3 of Form C to this schedule.

14. Total length of interview______________________

15. To what extent did the respondent seem interested in the subject matter of the interview?

16. Check all applicable items:

Respondent seemed:

_____Straightforward

_____Evasive

_____Knowledgeable

_____Uninformed

_____Obstructive

_____Cooperative

17. Provide any comments about the interview or the respondent you feel are pertinent for evaluating the validity and relevance of the information obtained during the interview. (Relate comments to checked items in Question 16.)

18. Identify any inconsistencies between respondent's comments during Phase I and Phase II interviews (applies only to the respondents interviewed in both phases).

EXHIBIT K-4

HEAD START IMPACTS STUDY - PHASE II

FORM D

SUMMARY SHEET TO ACCOMPANY FINAL NARRATIVE REPORT

INSTRUCTIONS

It will be necessary for you to fill out completely one copy of Form D to accompany your final narrative report which presents the data you have obtained during your investigation. The final narrative report should focus on the major influences leading to the change you investigate. In this report you should summarize the findings for each topic area listed in Forms B and C, focusing on answers to the following questions:

What caused the change?

How and in what sequence did the change develop?

What organizations and individuals were involved?

How was the change implemented?

What period of time was involved between initiation of concept for change and its actual implementation?

What conflicts occurred during this time period and how were they resolved?

What role (if any) did Head Start assume with respect to the change?

Since the role of the local Head Start program, its personnel, or just Head Start concepts (irrespective of geographic locus) are of particular importance to this research, your narrative report should contain a specific statement about Head Start's role in the change process. Your statement should either (1) explain the role of Head Start in bringing about the change, (2) indicate that Head Start was not involved, or (3) if necessary, explain why the role of Head Start remains unknown. Remember, Head Start or any other group can be said to have played a role, without having been an active advocate for change, by providing an example of what to do or how to do it.

Be sure to review all areas of interest contained in Form B before beginning your final narrative report to make sure that you give attention to all areas of importance and all respondents' remarks. Where different respondents have given contradictory information about particular circumstances and events, you should explain why you accept one interpretation among several. Be sure to identify your own opinions and judgments as such.

Please prepare your narrative report as soon as you have completed your investigation. Your report should be typed but it does not have to be in final manuscript form. Please instruct your typist to leave a 1½-inch right margin on each page of your report.

For Office Use
Only

Appendix K

Interviewer____

Target Community____________________________________

Description of change investigated (Abstract):

For Office
Use Only

HEAD START IMPACTS STUDY - PHASE II

FORM D

Interviewer________________ Date Form D Completed________________

Target Community________________ State________________

(1)	(2)	(3) Respondent's remarks consistent with those offered during Phase I. (See Question 18, Form B or C.)		(4) Did respondent report Head Start to be a causal factor for change investigated? (Check after Phase II interview.)	
RESPONDENT'S NAME	TITLE	YES	NO	YES	NO

Other Data Sources:

APPENDIX L

CHARACTERISTICS OF PHASE II RESPONDENTS

TABLE L-1: Distribution of Phase II Respondents According to Institution/Agency

TABLE L-2: Distribution of Phase II Respondents According to Selected Characteristics

TABLE L-1

Distribution of Phase II Respondents According to Institution/Agency

Institution Represented	f	Percentage of Total Respondents
CAA	55	20
Head Start	59	21
Public Schools	102	36
Public Health	48	17
Private Health	4	1
Miscellaneous	14	5
Total	282	100

TABLE L-2

DISTRIBUTION OF PHASE II RESPONDENTS ACCORDING TO SELECTED CHARACTERISTICS (PERCENT.)

	AGE				SEX			ETHNICITY			
Type of Agency Represented by Respondent	40 and Under	41-50	51 and Over	Total	M	F	Total	Black	White	Spanish	Total
CAA/Head Start	55	30	15	100	49	51	100	48	47	5	100
Health	30	40	30	100	67	33	100	1	99	0	100
Schools	36	37	27	100	58	42	100	29	69	2	100
All Agencies	43	34	23	100	56	44	100	32	65	3	100

N = 250*

N = 243

N = 248

*N's represent only the numbers of respondents who were willing to provide information about their identity.

APPENDIX M

PROCESS FOR CODING PHASE II DATA

Code construction for an unstructured interview is always complex and it tends to be somewhat more complex when utilizing a composite of several interviews. Therefore, discussion of the method that was used to construct the code in Phase II is important in interpreting the study results.

As there was no strict question-by-question format to follow, code construction was based on the Interview Guide and Reporting Form outline (Appendix K) which defined the dimensions of project interest and suggested topics to be covered during each interview. Information from a preliminary reading of a representative sample of composite interview narratives (Form D's) was also utilized as an input for construction of the content code. We were particularly concerned that the code could handle all relevant information contained in the summary interviews. The resulting code then was constructed in outline form, with the outline "items" (these would be the "questions" in a conventional questionnaire design) closely paralleling the topics suggested in the Interview Guide and Reporting Form and providing very brief reminders of appropriate examples for the coders.

For each item in the outline, a range of response categories was provided into which the narrative information could be coded. A sampling of the summary narratives was made in order to determine the kinds of response given for each item. This enabled response categories to be selected which would accurately reflect the content and scope of information contained in the Form D's while at the same time expressing this information in terms relevant to project interests and goals.[1] Since the number of summary

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[1] As with the outline items themselves, provision was made either to add or eliminate response categories during coding if subsequent reading of further narratives deemed this necessary. Few alterations were necessary, however.

Form D's was small (47), many code categories were necessarily rather broad in order not to have an unmanageably large number of narrow categories.[1] Unique and specific code numbers were then assigned to each code category; during the coding process information was extracted from the Form D's and translated into the code. Subsequently the usual but time-consuming quality control checks of double coding, reconciliation, punching, verification, computer card image checks, and internal computer checks for logical coding discrepancies were made.

A copy of the complete instrument used in coding can be made available on request. The code is composed of six "cards" (referring to IBM cards), each card containing space for eighty digits representing the coded values. Every code item is represented by a particular column or columns, the number being determined by how many code-number digits are used to represent its response categories.

On all cards the format is essentially the same. The first fifteen items (22 columns) represent background or identification information about the impact studied, the community, and its Head Start program, including independent variable measures. Following these items are the content items--different for each card--which represent the information pertaining to the topics outlined in the interview form. Finally, there is a group of blank columns[2] followed by several more identification indices and the card number designation.

The content items of the first three cards parallel the topics outlined in Form B concerning the course of process of the impact studied in each community. The primary focus is on the recording of all organizations and persons involved in each phase of the change process,[1] the methods they used to bring about change, and the motivations behind their involvement. Durations between phases are recorded where possible. This is followed by a recording of the target population characteristics, the assessment of its success or failure, and the presence or absence of modifications occurring during the course of the impact itself. The first three cards of the code, then, represent a record of the change process as it relates to the entire organizational network of the community.

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[1] Many statistical operations require that a sufficient number of cases be present in each category or "cell."

[2] These blank columns allow space for coding additional information if desired in the future without going to the expense of punching new cards.

Since a major project goal is to examine the particular role played by Head Start in the changes studied, the final three cards of the code deal with the involvement of this organization throughout the change process phases. These "Head Start" cards essentially repeat the format of the first three cards. Only the presence or absence of Head Start involvement during each phase, the methods used by Head Start personnel, and the motivations behind Head Start participation are of concern.

Coding of the 47 narrative summaries (Form D's) was directed by two full-time coding supervisors who trained a staff of four part-time coders, answered questions, and generally managed coding procedures. All Form D's were coded independently by two separate coders and, where necessary, reconciled. When important items were not reported on in the composite Form D summaries, individual interview schedules (Form B's) were referred to in an attempt to locate the information and thus obtain a more complete record of the change process in question. When that could not be done, additional interviewing was performed to secure the necessary information. When a Form D, supplemented if necessary by its Form B's or additional interviews, had been coded (that is, when response categories had been classified according to the code), the code numbers corresponding to the selected categories were recorded on special "coding sheets." Each coding sheet contained eighty cells, corresponding to the eighty columns on the IBM cards used. For each Form D, six such sheets were used--one for each card--and the selected code numbers were entered in the appropriate cells. This transcription process was also double-checked to minimize further errors by means of double coding, punch card verification, and by verification against computer card-image printouts.

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[1] Involvement in the change is seen as possible at seven separate phases or stages of its progression: in the background environment setting the "climate" for change, in its initiation or proposal, in support or opposition to its adoption, in its authorization, in providing its funds and resources, in its actual execution, and in cooperation or support during its execution.

APPENDIX TABLE N-1

MATCHED HEAD START AND NON-HEAD START COMMUNITIES FOR COMPARISON PURPOSES*

Head Start Communities			Comparison Communities		
City (County)	Population**	Head Start Project Predominant Clientele Ethnicity	City (County)	Population**	Head Start Status
Bentonville, Ark. (Benton)	4,519	Negro	Dumas, Ark. (Desha)	4,213	No Program
Ville Platte, La. (Evangeline)	7,512	Negro	Cairo, Ga. (Grady)	7,427	Summer Head Start 1966
Newton, Miss. (Newton)	3,178	Negro	Pelham, Ga. (Mitchell)	4,609	Summer Head Start 1966
Poteau, Okla. (Le Flore)	4,428	Anglo	Dawson, Ga. (Terrell)	5,062	No Program
Atlantic City, N.J. (Atlantic)	59,000	Negro	Bloomfield, N.J. (Essex)	51,867	No Program
Mitchell, S.D. (Davidson)	12,555	Anglo	Huron, S.D. (Beadle)	14,180	No Program
Perris, Cal. (Riverside)	2,950	Spanish-American	Marina, Cal. (Monterey)	3,310	No Program

* Matched for community size, regional locale, ethnicity, and presence of a poverty population.

** 1960 Census of Population.

APPENDIX TABLE O-1

Frequency of Various Ways in Which Head Start Participated During Background Stage According to Parent Participation Level

Type of Background Factor	Number of Cases			
	High Parent Participation Centers		Low Parent Participation Centers	
	f*	%*	f*	%*
Economic, Legal	4	28.6	1	4.0
Personnel	1	7.1	3	12.0
Organizational	7	50.0	3	12.0
Psychological Climate	9	64.3	14	56.0
Physical, Extraneous	1	7.1	2	8.0
Setting an Example	9	64.3	23	92.0
Other	0	0.0	0	0.0
NA	1	7.1	1	4.0

N High Parent Participation = 16

N Low Parent Participation = 31

* Percents exclude those impact cases--2 "High" and 6 "Low" parent participation centers--where Head Start was definitely not mentioned as participating in the background stage and are based on total N's of 14 (not 16) "High" and 25 (not 31) "Low" parent participation cases where Head Start was either definitely involved as background or where it could not be ascertained (NA) if Head Start was involved.

Total frequencies and percentages can equal more than 14 "High" and 25 "Low" parent participation cases since more than one background factor can apply in a single case.

APPENDIX TABLE 0-2

Frequency of Use of Various Methods by Head Start to Support Change Adoption According to Parent Participation Level

Type of Method Used by Head Start	Number of Cases			
	High Parent Participation		Low Parent Participation	
	f*	%*	f*	%*
Direct Action	11	84.6	18	90.0
Influence on Other Organizations	3	23.1	9	45.0
Influence on Private Persons, Groups	5	38.5	4	20.0
Emotional Reaction	1	7.7	0	0.0
Other	0	0.0	0	0.0
NA	1	7.7	0	0.0

N High Parent Participation = 16
N Low Parent Participation = 31

* Frequencies and percentages exclude those impact cases--3 "High" and 11 "Low" parent participation centers--where Head Start was definitely not mentioned as participating in the support for change adoption and are based on total N's of 13 (not 16) "High" and 20 (not 31) "Low" parent participation cases where Head Start was either definitely involved as supporter of change adoption or where it could not be ascertained (NA) if Head Start was involved.

Total f's can equal more than 13 "High" and 20 "Low" parent participation cases since more than one method could be used in a single case.

APPENDIX TABLE O-3

Frequency of Use of Various Methods by Head Start to Support or Cooperate During Change Execution According to Level of Parent Participation Level

Type of Method	Number of Cases			
	High Parent Participation Centers		Low Parent Participation Centers	
	f*	%*	f*	%*
Direct Action	11	84.6	17	81.0
Influence on Other Organizations	4	30.8	6	28.6
Influence on Private Persons, Groups	8	61.5	9	42.9
Emotional Reaction	0	0.0	1	4.8
Other	0	0.0	0	0.0

N High Parent Participation = 16

N Low Parent Participation = 31

* Frequencies and percentages exclude those impact cases--3 "High" and 10 "Low" parent participation centers--where Head Start was not mentioned as participating in support during change execution and are based on total N's of 13 (not 16) "High" and 21 (not 31) "Low" parent participation cases where Head Start was involved as cooperator during change execution.

Total f's can equal more than 13 "High" and 21 "Low" parent participation cases since more than one method could be used in a single case.

APPENDIX TABLE P-1

Frequency of Various Ways in Which Head Start Participated During Background Stage According to Type of Delegate Agency

Type of Background Factor	Number of Cases*			
	Public School Delegate Agencies		"New" Delegate Agencies	
	f**	%**	f**	%**
Economic, Legal	0	0.0	2	12.5
Personnel	1	6.3	2	12.5
Organizational	3	18.8	0	0.0
Psychological Climate	7	43.8	10	62.5
Physical, Extraneous	0	0.0	2	12.5
Setting an Example	16	100.0	13	81.3
Other	0	0.0	0	0.0
NA	1	6.3	0	0.0

N Public School centers = 20

N New Agency centers = 18

* Nine cases where Head Start had "Traditional" or "Mixed" delegate agencies are excluded. Total N is 38 (not 47) cases.

** Frequencies and percentages exclude those impact cases--4 Public School and 2 "New" agency centers--where Head Start was not mentioned as participating in the background stage and are based on total N's of 16 (not 20) Public School and 16 (not 18) "New" agency cases where Head Start was either definitely involved as background or where it could not be ascertained (NA) if Head Start was involved. Total f's can equal more than 16 Public School and 16 "New" agency cases since more than one background factor can apply in a single case.

APPENDIX TABLE P-2

Frequency of Use of Various Methods by Head Start to Support Change Adoption According to Type of Delegate Agency

Type of Method	Number of Cases*			
	Public School Delegate Agencies		"New" Delegate Agencies	
	f**	%**	f**	%**
Direct Action	11	91.7	12	92.3
Influence on Other Organizations	4	33.3	5	38.5
Influence on Private Persons, Groups	2	16.7	5	38.5
Emotional Reaction	0	0.0	0	0.0
Other	0	0.0	0	0.0
NA	0	0.0	0	0.0

N Public School centers = 20

N New Agency centers = 18

* Nine cases where Head Start centers had "Traditional" or "Mixed" delegate agencies are excluded. Total N is 38 (not 47) cases.

** Frequencies and percentages exclude those impact cases--8 Public School and 5 "New" agency centers--where Head Start was not mentioned as participating as a supporter for change adoption and are based on total N's of 12 (not 20) Public School and 13 (not 18) "New" agency cases where Head Start was involved as a supporter of change adoption. Total f's can equal more than 12 Public School and 13 "New" agency cases since more than one method could be used in a single case.

APPENDIX TABLE P-3

Frequency of Use of Various Methods by Head Start to Support or Cooperate During Change Execution According to Type of Delegate Agency

Type of Method	Number of Cases*			
	Public School Delegate Agencies		"New" Delegate Agencies	
	f**	%**	f**	%**
Direct Action	13	81.3	9	81.8
Influence on Other Organizations	4	25.0	4	36.4
Influence on Private Persons, Groups	8	50.0	4	36.4
Emotional Reaction	0	0.0	1	9.1
Other	0	0.0	0	0.0

N Public School centers = 20

N New Agency centers = 18

* Nine cases where Head Start centers had "Traditional" or "Mixed" delegate agencies are excluded. Total N is 38 (not 47) cases.

** Frequencies and percentages exclude those impact cases--4 Public School and 7 "New" agency centers--where Head Start was not mentioned as participating in support during change execution and are based on total N's of 16 (not 20) Public School and 11 (not 18) "New" agency cases where Head Start was involved as a cooperator during change execution. Total f's can equal more than 16 Public School and 11 "New" agency cases since more than one method could be used in a single case.

APPENDIX TABLE Q-1

Frequency of Various Ways in Which Head Start Participated During Background Stage of Health and Educational Changes

Type of Background Factor	Number of Cases			
	Health Area		Education Area	
	f*	%*	f*	%*
Economic, Legal	2	18.1	3	10.7
Personnel	3	27.3	1	3.6
Organizational	4	36.4	6	21.4
Psychological Climate	7	63.6	16	57.1
Physical, Extraneous	1	9.1	2	7.1
Setting an Example	7	63.6	25	89.3
Other	0	0.0	0	0.0
NA	0	0.0	2	7.1

N Health = 15
N Education = 32

* Frequencies and percentages exclude those 4 health and 4 education impact cases where Head Start was not mentioned as participating in the background stage and are based on total N's of 11 (not 15) health and 28 (not 32) education impact cases where Head Start was either definitely involved as background or where it could not be ascertained (NA) if Head Start was involved or not.

Total f's can equal more than 11 health or 28 education cases since more than one background factor can apply in a single case.

APPENDIX TABLE Q-2

Frequency of Use of Various Methods by Head Start to Support Adoption of Health and Educational Changes

Type of Method	Number of Cases			
	Health Area		Education Area	
	f*	%*	f*	%*
Direct Action	11	84.6	18	90.0
Influence on Other Organizations	5	38.5	7	35.0
Influence on Private Persons, Groups	2	15.4	7	35.0
Emotional Reaction	1	7.7	0	0.0
Other	0	0.0	0	0.0
NA	1	7.7	0	0.0

N Health = 15
N Education = 32

*Frequencies and percentages exclude those 2 health and 12 education impact cases where Head Start was not mentioned as participating in the support for change adoption and are based on total N's of 13 (not 15) health and 20 (not 32) education impact cases where Head Start was involved as a supporter of change adoption or where it could not be ascertained (NA) if Head Start was involved.

Total f's can equal more than 13 health and 20 education cases since more than one method could be used in a single case.

APPENDIX TABLE Q-3

Frequency of Use of Various Methods by Head Start to Support or Cooperate During Execution of Health and Educational Changes

Type of Method	Number of Cases			
	Health Area		Education Area	
	f*	%*	f*	%*
Direct Action	11	84.6	17	81.0
Influence on Other Organizations	4	30.8	6	28.6
Influence on Private Persons, Groups	8	61.5	9	42.9
Emotional Reaction	0	0.0	1	4.8
Other	0	0.0	0	0.0

N Health = 15 (100%)
N Education = 32 (100%)

*Frequencies and percentages exclude 2 health and 11 education impact cases where Head Start was not mentioned as participating in support during change execution and are based on total N's of 13 (not 15) health and 21 (not 32) education impact cases where Head Start was involved as cooperator during change execution.

Total f's can equal more than 13 health and 21 education cases since more than one method could be used in a single case.

APPENDIX R

ILLUSTRATIVE RESPONSE MATERIALS FROM THE SECOND INTERVIEW WAVE

This Appendix contains Narrative Summary Reports received from two of the second-wave communities. The two reports were selected to be representative of the total sample of reports with respect to quality, intensiveness, and type of change studied.

The following narrative summary reports have been slightly edited by the central staff in order to delete names of communities and respondents and thereby insure confidentiality of those interviewed.

CHANGES IN HEALTH SERVICES FOR THE POOR IN A LARGE NORTHEASTERN CITY

INTRODUCTION

Although black poverty is a political problem, the best way to solve it is by avoiding local politics. This paradoxical lesson comes repeatedly and in various forms from successful community action in this city.

Three principles explain why in this city with its high rate of economic absenteeism, history of political corruption and tradition of ethnic strife, black community action has reached relatively outstanding results. These principles are:

1. Avoidance of local politics. The leaders of the local CAO and Head Start--although deeply rooted in the community--are basically from non-political origins. The CAO Director is owner of a local black newspaper, and the Coordinator of Educational Services, a former professional educator. Their non-political approach evokes widespread confidence from both the black and white sections of the population. Equally important is that the funds for their projects come predominantly from federal sources.

2. Operation by professionals. The impact studied, i.e., Head Start's effects in the health and medical areas, is mainly executed by university-educated professionals in public and academic institutions--the County Health Department and the medical and health-related faculties of the rapidly expanding local branch of the State University. The close cooperation between these two institutions has benefits for both and, indirectly, for the core area. The possibility of joint appointments in the County Health Department and the State University enables the Department to attract more highly qualified staff personnel, and has a stimulating effect upon the University's

health-related disciplines. Still, their efforts would be much less oriented to the core area without the following factor.

3. Involvement of voluntary participants. It has been asserted by many officials that two groups of volunteers have been crucially important for Head Start's greater impact in the health sector. One consists of citizens from the core area, overwhelmingly Head Start parents and tutors, and the other consists of white University students. Committees of black volunteers have exerted pressure upon the County Health Department to expand its medical services in the core area, and committees of (white) students have had a similar effect upon the University's orientation toward the community. In the two most spectacular institutional spinoffs from the local Head Start program, black participants and graduate students played strategically crucial roles.

The first spinoff is in the area of disease prevention, i.e., a new consumers' cooperative providing families in the core area with inexpensive fresh fruit and vegetables. The second has a direct therapeutic function--a new neighborhood medical clinic in an isolated and poverty stricken "Steeltown." Before analyzing these spinoffs we will first describe Head Start's medical functions.

HEAD START'S MEDICAL FUNCTIONS

The local Head Start consists of four delegate agencies operating fifteen centers, all located in the core area. Its health division consists of two programs, an all-year program with 655 children and a summer program with 515 children. Because the parents are involved, the educational aspects of the program reach between 2,000 and 3,000 people. All its health services are organized and provided by the County Department of Health. They include: physical examinations, hearing and vision screening, urinalysis, tuberculosis testing, immunization and follow-up of all defects with correction where possible. In addition, dental examinations and care are provided in four preschool programs of the Bethel Head Start Center.

To view this project in its just proportions, we have to present the other services in the poverty areas provided by the County Health Department. These are:

1. Maternity and Infant Care project operated in conjunction with the University, consisting of four prenatal clinics for mothers in the core area and one high-risk clinic for infants. Since the start of this service in December 1966, 500 mothers have received service.

2. Out-of-Wedlock Mothers under 18 years, serving about 80 girls at any one time.

3. Special premature program operating in three centers for premature infants weighing less than 4½ pounds.

4. Five full-time dental clinics with modern, high-speed equipment, serving children from the core area. The care includes inspection, prophylaxis, referral, and topical fluoride applications. In addition, an educational program stressing prevention is presented. Also, five dental students accompany health guides to the city's core area.

5. Comprehensive services to all children in Community Action Programs, similar to the Head Start services.

6. School health services to all children in the city.

7. A venereal disease diagnostic and treatment clinic, serving largely those residing in the central city. In 1967, 5,817 patients visited the clinics.

8. Two nursing offices, providing home care and health supervision in the central city.

9. Immunization service, with special programs in the core area for poliomyelitis and, recently, measles. The latter

(in 1967) covered more than 40,000 children, 11,000 of which were Negro.

10. With 11 clinics in the core area and 12 on the fringe of the core area, 23 clinics largely serve the low socioeconomic groups in child health care. More than 22 percent of the newborn in the city attend the well-baby clinics.

11. The office of Public Health Education has been devoting more and more time to the core area: a health fair, venereal disease education, sex education; also, 50 health guides are bridging the gap between the core area's medical needs and existing public services, serving 3,500 individuals in one year.

12. Tuberculosis detection and treatment services in the core area.

13. A formal rodent program, employing 50 males from the core area.

When evaluating Head Start's spinoff, one should view it against the background of this diversified program of health services already offered by the County Health Department. The better and broader these services, the less room there is for Head Start to introduce additional provisions. Such new and successful public programs as the 50 health guides, the one-million dollar rodent program with 50 core area exterminators, and the six dental clinics for children in the core area have all been achieved _without_ any noticeable influence from Head Start. The high quality of the existing health provisions also explains the _empirical_ findings by the Department's officials in the summer of 1966, that "children who participated in the summer Head Start program in the city were already of good health." And that "poverty money was used in this instance to give these children the health services routinely given by the County Health Department in the city schools three to five months ahead of the time they would ordinarily have received them," with the conclusion that "available poverty money can be directed to more needy areas of the nation."

Should we imply from these official and publicized findings that Head Start made no impact at all upon health services available to the poor in this city? The facts indicate this conclusion to be oversimplified. The two following illustrations of change indicate, however, that in a city with outstanding public health services in its core area, poverty money directed to Head Start's medical division might be transferred to its educational projects. For in both cases the effects of Head Start's educational, rather than health, programs directly or indirectly were instrumental in setting and attaining new goals.

THE ECCO CONSUMERS' COOPERATIVE

The Reasons for Change

It has been noticed that in the core areas of many cities prices are higher and qualities lower than in suburban stores. An official hearing in August 1968 by Congressman Rosenthal from Queens, New York proved that in this respect this community is no exception.

Mrs. Dorothy Teryl, Vice Chairman of the local Chapter of the American Civil Liberties Union, upon invitation from some members of the State's Congressional delegation, surveyed differences in prices, quality, and service in the local core area and suburbs. Mrs. Teryl reported to us that:

1. Overall, prices for identical items in the same supermarket chains were six percent higher in the ghetto. Differences were highest for perishable items, i.e., fruits, vegetables, and cheaper cuts of meat (bacon, bologna, hot dogs). Also, on "welfare days," prices of such items went up an average of ten cents.

2. Another observation was that for the same price, say a head of lettuce for 29 cents, the quality in the ghetto was far

inferior to that in the suburbs. Mrs. Teryl and her assistants noted "rotten, slimy and black" fruits and vegetables. The bananas were often pure black, without a speck of yellow.

3. Checking prices mentioned in advertisements with those in the stores, it was found that of 108 items advertised at discount prices, only 85 were available in ghetto stores. Of these, 16 were grossly overpriced, one item by 22 cents, others by 10 to 12 cents. It was noticed that in suburban stores, prices exactly conform to ads. When black shoppers brought the differences between pricing and advertisements to the attention of ghetto store managers, the latter frequently reacted in abusive ways, shouting and threatening.

These facts were notarized and reported to the Congressional delegation in Washington. A new survey, utilizing graduate law students, is now under way.

The effect of this economic exploitation upon a population with a high rate of welfare recipients is close to disastrous. Official records show that approximately 43 percent of the tuberculosis patients of this county reside in the core area of the city, with approximately 200 having active disease. Low incomes and low education levels are indicated as factors complicating therapy and prevention. What is needed are lower prices and higher quality, especially of easily perishable foods and, in addition, consumer education for core-area housewives.

The Origins of Change

All these findings became gradually known to the core area's opinion leaders who predominantly consist of Head Start parents and tutors. And as it happened, several causal factors coincided in creating a "decisive stage" of social change. One such factor was that health guides, worried about the high TB rate, informed core-area housewives about the lack in their family diets of fresh fruit and vegetables. Another factor was that two Head Start tutors brought some housewives together to talk about ways to alleviate exploitation of core-area consumers. A third factor was that a board member of Head Start's "Wider Horizons" voluntarily attended a credit-union management seminar. A fourth factor was that through "Wider Horizons" he got in touch with a University professor of social welfare, who had recently founded consumers' cooperatives in the ghetto of Detroit. As a result of the interplay of these factors, the East-Side Community Cooperative Organization (ECCO) was founded September 18, 1968.

Essentially for the occurrence of such a decisive stage of social change is the availability of black opinion leaders who have the confidence of core-area inhabitants, the education to communicate new information, the contacts to relate to academic or public officials, and the initiative to start and run a committee or organization. In these combined roles they function as the agents of social change. In the case of ECCO, Head Start parents and tutors acted as opinion leaders in the core area.

But besides this indirect role in this case of social change, Head Start also fulfilled more direct functions.

Advocates and Supporters of Change

In this first year of its existence, outside support of ECCO has been rather small. The Model Cities program attracted a few black leaders from other cities to inform ECCO participants about their own experiences with consumers' cooperatives. The FDA in Washington has sent an expert to speak at a consumers' education meeting. Also, two University professors served as advisers. But the main thrust has come from the core-area inhabitants themselves, to the effect that in less than one year, 150 volunteers are involved and 30 sales have been conducted, averaging 315 units (i.e., bags with fruits and vegetables) per sale.

How has this come about? Through the use of hard facts, the most convincing instrument of persuasion.

Implementation of Change

September 25, 1968 the planning started for a demonstration sale, intended to propagate the advantages of a consumers' cooperative to the black community. A questionnaire and flier were sent out to inform the area about the plans. September 30, prices were checked at the farmers' market and the first order blanks were distributed to six Head Start centers, where mothers daily come with their children. October 2, a total of 132 orders were collected and the next day six volunteers purchased the fruit and vegetables. They also bought bags and provided transport. October 4, a group of 15 volunteers bagged these goods for one hour at the Salem UCC Head Start center. The next day, six volunteers were responsible for the sale of the bags. Checked with core-area stores, the same goods were sold there at the following prices:

5 lbs. potatoes	$ .29
5 lbs. apples	.39
2 lbs. tomatos	.29
3 lbs. onions	.39
2 bunch greens	.49
1 hd. cabbage	.15
	$2.00

With the same amount (and probably better quality) of vegetable products sold by ECCO for $1.25, this represented a savings of $.75 or 37.5 percent. Understandingly, this demonstration sale was quite effective in convincing core-area housewives of the advantages of block buying of perishable foods.

Magnitude and Assessment of Change

When on June 28, 1969, sales were temporarily stopped for the summer because of the lack of refrigeration, 30 sales had been conducted in 40 weeks, and the initial 132 units had increased to an average of 300 bags per sale.

There was a consensus among respondents that families buying ECCO foodbags had saved an average of $5.00 per month. This leads, on the basis of (315 x 30/4 x $5.00), to a rough estimation of total savings in the black community of at least $10,000 within a period of 7½ months, not counting the health benefits deriving from the consumption of higher quality fruits and vegetables in this tuberculosis-ridden area.

With regard to the initial apathy and skepticism, another result should be mentioned. It is that more than 150 persons in this community, almost all housewives, have been actively participating on a voluntary basis in weekly buying, transporting, bagging, and selling these foods. Although hard to measure, there is little doubt that this has instilled a greater sense of confidence and hope in the community. This group consists entirely of core-area inhabitants.

A third result, again, is hard to measure. It is that stores in the area recently have started "sales" of the same goods sold that week by the ECCO cooperative. It is hard to prove this to be a direct effect of their endeavor, but the housewives asserted that such sales had never been held before.

Another part of this Head Start spinoff is that a series of consumer education sessions were organized and attended by 25 to 40 housewives from the core area. Besides instruction about the principles and practice of consumers' cooperatives, the sessions dealt with saving money on meat purchases, clothing, managing money, credit unions, housing, and transportation. All classes were held at ECCO headquarters.

The successful cooperation between ECCO and the University professor has facilitated the founding of a Center for Technical Assistance and Community Planning in the School of Welfare at the University, with the professor as its Director. The Center is expected to widen the support given to ECCO by members of the University faculty.

Finally, this is a project with a strong unifying impact upon the black community. Nonpolitical and nonreligious as it is, the ECCO cooperative has been able to attract participation from many private and public social welfare agencies and religious groups. Underlined are the Head Start centers which provided space for distributing and collecting order forms and selling the food bags.

As yet no opposition against ECCO has been noticed. The leaders expect some resistance from neighborhood stores and shopkeepers when sales expand and when the operations, which are now spread over the area, are concentrated in a CO-OP shop.

The Future of ECCO

We consider ECCO's future to be bright. According to the experience that nothing breeds success like success, State University students, from the benefits of their "March for Freedom," have recently donated $16,000 to the cooperative. In addition, 422 shares at $5.00 a share have been sold, resulting in a total reserve of $18,120. The plans are to use this as founding capital for a supermarket, although a recent boycott by local pharmacists of Medicaid and Welfare programs also indicate a need for a pharmaceutical co-op. After my extensive interviews with various participants and advisers of this project, I am convinced that the ECCO cooperative has the leadership potential for a similar expansion as shown 20 to 30 years ago by the co-ops in various European nations.

The Role of Head Start

Head Start has played an indispensible role, indirectly and directly, in this cooperative effort--indirectly because the ECCO Chairman was a member of the Board on one of the Head Start delegate agencies, and because the housewives who took the first initiative were tutors in Head Start programs or parents of children who attended these programs; and directly, because Head Start provided this project with the necessary space for distributing and collecting order forms from core-area housewives and for selling the goods.

THE COMMUNITY HEALTH CENTER

Reasons for Change

The town in which this health center is located lies in an isolated area, about 15 minutes driving from the heart of a large city, adjoining the sprawling plant of Bethlehem Steel. Its inhabitants live eternally under the brown and smelling cloud of smog which is characteristic for this industrial area. Researchers have found the rate of respiratory illnesses in this town significantly higher than in less-polluted parts of the city. The visitor is reminded of the industrial towns in the English Midlands and Northwest about one century ago.

The reasons for wanting a community health center are defined differently by different groups and this diverging argumentation was one of the first obstacles that had to be overcome. The poor Negroes and Puerto Ricans simply wanted shorter waiting hours for their medical needs, more thorough treatment of their illnesses, and more personalized relationships with their physicians. But public authorities cannot do much with such demands; what they need are such facts as these:

> Population: 5,700; 20% of which Negro, 2nd 20% Puerto Rican. According to the criteria of early syphillis, out-of-wedlock births, active cases of TB, infant mortality rate, and birth rate, this town is the sixth most unhealthy of all 30 of the city's wards. Medical facilities: one full-time physician and one part-time, both refusing Medicaid and Welfare. Distance from hospitals: 7 to 10 miles, with two changes of buses

required. For mothers with two or more children, it is almost impossible to make this trip, with babysitters hard to find. Once she reaches the clinic, the mother must wait about 3 to 4 hours to be seen for a brief examination. If she has to come back (most cases) she never sees the same intern. The overcrowded and understaffed hospital clinic absolutely fails in educating its patients.

Although the city itself has outstanding public health facilities, provided by the County Department of Health, the officials of this department had evidently been unable to improve the above situation. Public officials are limited in their opportunities for innovation and often community pressure is required before they are able to act. In the case of this new clinic, the pressure came from two highly different groups: a number of Head Start parents and tutors, and about 15 graduate students of the School of Medicine of the State University.

Origins of Change

As with the consumers' cooperative, the initiative for the new clinic was predominantly with a small group of area housewives. One of these women was assistant social worker at a local Family Counseling Center, in the "reach out" program through which she visited families in need of help. Another, the wife of a hospital intern, was President of the Parents' Council of Head Start, and another was one of the Head Start mothers.

The social worker had become aware of the two basic needs in the community: economic poverty and poor health. She and the two other women often talked about the health situation, and in August 1967 they sent out a flier inviting people to come to a meeting. The occasion was a recent mass innoculation for measles, propagated by the local CAO and executed by the County Health

Department. The attending thirty people from the black, white, and Puerto Rican sections of the town formed the First Ward Health Committee.

Followed a long series of frustrating experiences. A visit with the Assistant Dean of the University's Medical School was disappointing. The arguments were that the University was not very interested in a neighborhood clinic, that it would turn out to be a failure, that the Medical School was not ready for such a clinic, and that such a clinic was planned elsewhere. Contacts with the Catholic neighborhood hospital were similarly disappointing, as it proved unable or unwilling to expand its out-patient clinic. Its services would remain confined to follow-up treatment of its own patients.

Supporters of Change

At this stage of ineffective initiatives, two tactical moves suddenly proved of strategic importance. One was the effort by a VISTA volunteer and a CAO social welfare official in composing a bio-statistical fact sheet. This provided the committee's qualitative demands with the quantitative backing needed to convince outsiders and officials. Later, the social worker would say that if she had to start all over again, the preparation of such a bio-statistical report would be her first step.

The second move was that the Head Start Parents' Council President, uninvited and unannounced, attended a meeting of graduate students of the University's Medical School, and told them about the First Ward's decrepit medical situation. As a result, 15 medical students started coming into the community, attending social meetings, and putting pressure upon the Medical School to get involved. This led to the founding of an eighteen-member Board of Directors, consisting of one-third community people, one-third medical students, and one-third University instructors. After this step the Commissioner of the County Health Department was invited to ex officio attend the Board's meetings, which subsequently led to his official support. The various factors operating at this crucial stage are quoted from the Commissioner's interview:

> While the Medical School's initial reaction was of disinterest, the pressure by the graduate students has been of tremendous importance.
>
> Interesting enough, for 5 or 6 months they visited various agencies without result before coming to the County Health Department.
>
> When they finally came I agreed with their plans on the condition that the clinic's medical director would be provided by the Medical School. It is very difficult for a Department of Public Health to attract physicians. After the students' pressure, the Medical School without hesitation agreed to appoint a Director of the clinic who would also be related to the School.

Several variables, positive and negative, are evident in this testimony. First, the University's traditional policy was only changed because of pressure by the students. Second, the students' mistrust of the County's official medical establishment resulted in a delay of about six months. Third, the public official--although aware of the initiative--could not act before being directly approached by members from the community. Fourth, this new neighborhood clinic could only get off the ground by concerted action between two medical institutions--the County Health Department and the University's Medical School.

It is clear that without a group of skilled opinion leaders in the community, this complicated chain of events would never have led to its successful result. It is to the merit of Head Start that it provided the salaries, education, and prestige required for the existence of these opinion leaders.

Opponents of Change

The students' mistrust of the establishment had not been entirely without grounds. Their own University was little interested and after some initial moves is now pulling out of the clinic. The American Medical Association voiced doubts, and even stronger resistance came from members of the black medical organization. The latter feared unfair competition and is still opposing the founding of new neighborhood clinics in the core area instead of expanding the role of existing hospital clinics.

Resistance was also offered by the staff of the neighborhood's small Catholic hospital which, although unwilling to expand its out-patient clinic, denounced a center of this nature as "close to socialism."

Finally, resistance and doubt came from the town's inhabitants themselves. Living in an isolated community and too often used as subjects of irrelevant research, they were suspicious of the outsiders. They gave the 15 visiting students a hard time, and the latter could only get accepted by attending numerous social meetings. Later, when the Board was founded, they objected to the fact that the community held only one-third of the seats, fearing to be outvoted by combined students and faculty. This fear proved to be unjustified as the students usually tended to accept the community's point of view.

A most serious threat to the clinic was presented by its first Director, a member of the faculty of the Medical School. This University official, a basic clinician, proved unable or unwilling to manage this type of neighborhood clinic. Within a few months its operation assumed chaos of such proportions that patients stayed away. Authority conflicts arose between nurses and students, available social welfare students were not utilized, and the members of the community had lost touch with the clinic's operation. The first director's replacement by an epidemiologist, an assistant Commissioner of Health, has saved the clinic.

Implementation of Change

Important is that the community members are playing a crucial role in the stage of implementation during the clinic's first few months of existence. When the first Director led the clinic into chaos, the three members of the community began to meet with a visiting epidemiologist, and to give him feedback about the patients' complaints and about the conflicts among employees and students. The community members also took the initiative in asking for the first Director's resignation, which was unanimously accepted by faculty and students. They further proposed that the epidemiologist be the new Director and after his appointment stayed in communication with him.

The input of students and faculty is now gradually fading away, and the community members feel that they should be replaced by more community members. (One respondent said "students are fine for initiating change, not for maintaining and operating the new institution.") The new Director, a former Peace Corps volunteer, defined this new Board as a "consumer committee" with the task of defining the community's needs in the broadest sense, leading to possible expansion in the areas of suicide prevention, maternal and child care education, and care of chronic diseases. Each of these expansions will lead to closer ties between the clinic and the community.

Assessment of Change

In the period April, May, and June 1969, the clinic's operations have greatly expanded. Instead of being open four times a week, it now opens ten times a week. In this same period the center has booked 1,067 single visits. Also, the new Director has been able to add a dental department to the center, the two chairs of which are now being booked no less than six weeks ahead.

The savings in time, sense of physical well being, and human happiness in the community deriving from the clinic's operation can be best estimated when compared with the fact-sheet describing the pre-clinic situation. Or, to quote the present Director, "We may not have an impact on longevity, but we certainly will have a positive impact upon perceived illness in the neighborhood." If this is one of the indirect and unintended benefits of the local Head Start program, it will certainly have justified the latter's existence.

CONCLUSION

Recently, Head Start has met with criticism. While Arthur R. Jensen[1] has created doubts about the effect of its educational operations, medical officials have uttered doubts about its effects on health.[2]

This indicates a possibility that in both the educational and medical sectors, Head Start's manifest functions have not met the initial expectations.

No such doubts should exist, however, about the Head Start project's latent functions. In both the ECCO cooperative and the neighborhood health clinic, it was found that Head Start parents and tutors were opinion leaders serving as agents of change. It was suggested by the Commissioner of Health that in this respect Head Start's latent functions, at least in this city, may well outweigh its manifest ones.

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[1] Arthur R. Jensen, "How Much can we Boost IQ and Scholarly Achievement?" Harvard Educational Review, Vol. 39, No. 1, Winter 1969, pp. 1-123.

[2] Ursula M. Anderson, Donald Bissell, William Mosher, "What Did Health do for Poverty prior to Poverty Programs?" New York State Journal of Medicine, Vol. 66, No. 19, October 1, 1966, pp. 2568-2572.

This leads to the following conclusions. While the professional nature of Head Start's medical program leaves little room for community participation, this is the opposite with Head Start education. Its many tutors, drawn from the core area, have the financial status, education, contacts, and prestige required of successful opinion leaders. Without this group of devoted adults, little change would have been initiated or implemented in the city's black ghetto. In the creation of these agents of social change, Head Start's educational division clearly plays a more important role than its medical division. While the indications are that, here, the latter could be well fulfilled by the County Health Department, no such substitute exists for its educational work. The advantage of such a transference would be that funds would become free for the expansion of Head Start's educational division and, indirectly, for the expansion of the black opinion leaders. Our two case studies suggest that this would have substantial spinoffs in social change and improvement of the city's black community.

THE USE OF TEACHER AIDES IN THE PUBLIC SCHOOLS IN A MEDIUM-SIZED COMMUNITY IN THE MIDWEST

BACKGROUND

The people I interviewed all agree that one man was by far the most prominent in seeking the change being investigated. When this all began this man was principal of Harrison School, an elementary school located in an area housing mainly poor blacks. He was contacted in the 1964-65 school year by a professor of education at a nearby university about the possibility of getting a Head Start (HS) program going. The principal was stimulated by the idea of such a program, and he did considerable reading on the rationale behind it, particularly the human development approach that HS was using. He was already very much aware of the fact that the kids coming into school from his area were not ready. The principal wrote the proposal for the community's first HS program, which started in the summer of 1965. He didn't run the program that summer because he had a long-standing summer job, but he did write the proposal for the first full-time HS program and he supervised the program for the HS director. Apparently the OEO regulations precluded the principal's being allowed to be director of the HS program. The Board of Education thus appointed a figurehead director and appointed the principal as a supervisor to actually run the program. This was borne out by the statements of several people I interviewed although obviously the school board officials omitted this feature of the program from their remarks.

HS began as a full-time program in the 1965-66 school year. In the summer of 1966, the regular HS teachers wanted a break, so the principal hired several kindergarten teachers to run the summer program in 1966. Thus, by the 1966-67 school year one elementary principal and several teachers had had some experience with teacher's aides (TA's).

Also in the summer of 1966 a tutorial program under Title I was tried in which college students majoring in education were used to reduce the pupil/teacher ratio (P/T) to 6 to 1. Test results showed improvements in reading and arithmetic significantly greater than in the normal 30 to 1 classroom. The results of this program sold the Superintendent's office on the value of lowering the P/T ratio.

The reading program, a program of long standing, had also shown that much better results could be gained in classes with fewer students. In this case the comparison was between the 30 to 1 classroom and a remedial reading teacher with a class of 10.

Thus, the HS program, the Title I tutorial program, and the remedial reading program all gave evidence of the fact that lowering the P/T ratio produced results. Further, HS and the Title I tutorial program showed that these improved results could be achieved even when professional teachers were not used to lower the P/T ratio. HS seems to have been more important in the minds of the teachers and principals, and the tutorial program seems to have been foremost in the minds of the school board administrators.

ORIGINS AND DEVELOPMENT OF THE CHANGE

Each year the Superintendent calls a meeting of a committee made up of the principals of the schools receiving Title I funds, the Assistant Superintendent for Federal Programs and the Assistant Superintendent for Curriculum. The purpose of this meeting is to set priorities for the use of Title I money. In January of 1967 the committee met to consider several items. During this meeting the Head Start director proposed the TA program as a solution to the problem of lowering P/T ratios. The immediate impetus for this proposal came from his personal experience with TA's plus pressure that several teachers had put on their principals. In fact, several teachers appear to have recommended the TA program to their principals independently. In retrospect the Head Start director feels that his selection of the kindergarten teachers he felt would work best with HS children also resulted in the selection of those who were most apt to become enthusiastic about the program. Several members of the committee supported the Head Start director's proposal.

The resistance to the program came mainly from a lack of enthusiasm by some principals who were either unable to see the need for TA's or more concerned with some other program. For example, one principal of two very small schools, which already have low P/T ratios, was lukewarm to the TA program.

The TA program was set somewhere in the top four priorities (everyone agrees on this, but just where in the top four it was is not certain). Even the secondary school principals supported the proposal at the expense of their own programs. As a matter of fact, no one who was in on that original meeting admits being opposed to the TA program.

One of the Head Start center directors supported the TA program with anecdotes from HS experience. This is an argument for having schools as delegate agencies. Otherwise, HS would have been in a less advantageous position to help throughout the decision to adopt the TA program and also during the implementation of the program.

The main obstacle to the original implementation of the TA program was money, and the main obstacle to its continuation and expansion is money. In concept, the idea is apparently difficult to oppose. There are two reasons for this: (1) it is a program which directly benefits the disadvantaged child, and (2) it reduces the PT ratio.

PHASES

In time sequence, the TA program in the city schools developed as follows:

Remedial reading program--before 1960.

1965	Summer HS
1966	Full-time HS in the fall Summer HS used kindergarten teachers Supervisor of HS was elementary principal
1967	January--TA's proposed and approved for schools March--9 TA's hired and placed
1967-68	19 TA's employed--funding taken over by state (ADC)
1968-69	21 TA's employed--local funding used to hire 2 TA's for non-core-area schools

IMPLEMENTATION OF THE CHANGE

It apparently took only a few weeks to implement the program once the decision was made. The meeting was held late in January, and the program was implemented in March. The program began with requests from core-area principals for TA's. The requests the first round were quite modest (some call them conservative), and for this reason funds were available to allow the School Board to honor all requests for TA's that first year. The Superintendent's office secured the list of applicants for TA jobs from the HS director. The HS director also recommended certain of his TA's for the school jobs. He looked on this as a promotion for them. Also, he was being forced to cut the number of TA's he was using due to cutbacks in funds from OEO. A representative of the school superintendent interviewed the applicants and assigned them to various schools.

The results of this procedure were less than satisfactory. Several mismatches caused some of the teachers to be very unhappy with the program. The following year the principals and their teachers interviewed the applicants and in essence chose the ones they wanted. Also the principals went out into the community and actively recruited people they thought would make good aides. At this point the concept of the TA began to drift away from the HS concept. The people in the schools became more concerned with the level of competence of the TA and in what the TA could do for them rather than in what they might be able to do for the TA. Also at this time requests for TA's were greater than the available funds.

The principals have a great deal of discretion [sic] in how they use their TA's. Some use them in pretty much the same way they are used in HS. Others use them in more custodial roles such as watching classes in the teacher's absence, or in administrative roles such as collecting money or working on bulletin boards.

The funding sources which have made the TA program a reality include Title I funds from the federal government and ADC funds from the State. At the beginning of the TA program, Title I money was used, but it became increasingly obvious that the continuation of the program under Title I would be difficult because of budget cutbacks.

Fortunately, the Ohio Legislature in 1967 passed Senate Bill 350 which allotted the core-area schools additional funds under the ADC program. Under this legislation, the schools got $50 per ADC child the first year of its operation. Later the amount was increased to $100 per child. The only stipulation is that the money must be used in a program which directly benefits the child. This ADC funding now assumes the full load for the TA program in core-area schools.

Should outside funds dry up, the TA program would be in real trouble, although the concensus is that it would be retained longer than most other "non-traditional" programs. In fact, two teachers aides are now being paid out of local funds at the expense of other programs.

The TA program is gradually spreading throughout the elementary schools in Hamilton. It started in three core-area schools and now six schools have teacher aides. This change is really a basic change for the system because ten years ago it would have been unthinkable to propose a "non-professional" to help lower the P/T ratio. In this regard HS's example opened up this entire area as a legitimate alternative. In fact, the legitimizing influence of HS is perhaps its greatest contribution. HS was acceptable to the general public, therefore anything borrowed from HS was defined as reasonable and proper.

It is surprising that civic groups, PTA's, etc., had absolutely nothing to do with initiating this change. Obviously they did not oppose it, but there was no agitation from outside at the beginning. Now it is a different story, however, particularly in the non-core-area schools. Parents in these districts are jealous that their kids are not getting the same advantages that kids in the poor areas get. It is significant that the only local money that has been spent on TA's went to "West-side" schools, those in well-to-do districts. This is perhaps a foreboding of what would happen to the program should the outside funds dry up. Based on what I have seen and heard, I would predict that the TA program could easily become a program for the middle class if federal and State restrictions were removed on how Title I and ADC money can be used.

This raises a complex issue concerning aid to the poor. Doubtless the TA program has benefited poor children in this community, but once the program spreads throughout the city it is conceivable that the same sort of problems will arise that now arise in the inner-city schools across the country. That is, given a choice, where will the best TA's go? Given a city-wide program, where is most of the money for the TA program apt to go? Where do the poor end up in this story? If the answers to these questions are the same for the local TA program as they have been for other programs in other cities, then the expansion of the TA concept to non-core-area schools is no blessing for the poor.

The local poor are not organized well enough to press their case for preferential treatment in terms of TA's or any other programs. Part of this results from the fact that here the poor are equally split between blacks and white Appalachian migrants. The antagonisms between the two groups make effective organization difficult, if not impossible.

Typical of the problem has been the development of pressure groups in the field of education. To begin with, there were the Concerned Citizens of the 2nd and 4th Wards, mainly an organization of poor blacks. They were successful in pressing home several changes in the local area schools. Subsequently the Citizens United for Better Education (CUBE) was organized citywide. CUBE has now successfully absorbed the Concerned Citizens, thus leaving the poor with no voice of their own. CUBE is headed by several influential white businessmen, and they have been instrumental in helping to implement several programs in core-area schools. At present their emphasis is on core-area problems, but there is no question where their loyalties would lie should there appear to be a conflict between the schools for the poor and the other schools. Right now CUBE sees no such conflict, but if they do in the future, my opinion is that the poor are going to be left high and dry although it may not be in such obvious terms.

One change which CUBE had a hand in was an outgrowth of the TA program--the Mother Corps. According to a core-area elementary principal, the object of the Moter Corps is to use volunteers to bridge the gap between what is needed in terms of TA's and what they have to work with. The Mother Corps seeks out solid, middle-class housewives who can help kids with reading, work in the library, etc. This informant says further that he gets anywhere from 20 to 40 hours of work per week from his volunteers. The idea of using volunteers grew directly out of HS.

Compared with HS, I would say that for two reasons the TA program probably has less direct impact on the lives of the poor: (1) the public schools' TA program does not stick very close to the goal of helping poor people by training them to be TA's, and (2) because many of the TA's are middle-class, they are not as capable of bridging the gap between the two cultures as the HS aides are. And as the TA program grows, it is probable that school officials will be less and less interested in what they can do for the TA.

Indirectly, the movement away from the HS concept of a TA may result in positive benefits for the poor by giving them a better education than they could get without the program.

It appears that HS played a vital role in bringing about this change here. In the beginning, through the experience of the principal and the teachers who took on the summer HS program and later through the support and advice of the Head Start director, the HS program was intimately involved in making the TA program a reality in the public schools. As the program grows and the schools gain more and more experience with TA's, it seems reasonable to expect a reduced role for HS, and this appears to be what has happened. However, HS is still and probably will continue to be an important source and training ground for public school TA's. It is questionable whether this role would be played by HS programs not associated with the schools.

One final comment: This change and the way it developed seems to vindicate the original decision to set up OEO as an organization separate from the existing system. It is very doubtful that if the school administrators had been in charge of HS originally there would have been any teacher aides in the program. The fact that OEO was free of existing institutional structure allowed it to innovate, and the results of this study show that OEO's innovation of the TA in HS paved the way for acceptance of his approach in the city schools.

Another issue which was raised and seems to merit attention is the visiting teacher program. This program calls for a social worker to visit the homes of children in the school and serve as a source of information and as a coordinator for the services of various agencies. A core-area school principal was the founder of this approach. He has tried to do this himself for many years, but since HS he has had more luck convincing others that this program has merit. The job description for the visiting teacher was taken directly from that for the Social Worker in HS, with the exception of the part about parents' meetings. Thus, the visiting teacher program was also given a big boost by HS.

As far as the future of the TA program here is concerned, the following points seem probable:

1. The program is here to stay. Even should outside funds be cut back, the program would remain in some form.

2. The poor will still benefit from the TA program even if they do not get disproportionate support for TA's in their schools as compared with middle-class schools.

3. The program will be expanded, particularly in the middle-class schools.

4. Support for expansion of the program is more apt to come from the middle class than from the poor of this community.

5. The TA will continue to be professionalized and taken further from the HS concept, particularly in the middle-class schools, but also in core-area schools.

6. Other programs such as field trips will be sacrificed in favor of the TA program.

7. State funds provide a better base for the program than Title I funds have done.

In observing the system of public education here I was impressed that in one form or another most of the significant elements of HS are now to be found in the elementary schools. And the schools did not have these elements before HS came along. Albeit some of these programs are small and somewhat ineffectual, the TA program, the Mother Corps, and the visiting teacher program all appear to have had at least part of their origins in HS, and of these three, the TA program is by far the most well developed.